REPORT OF THE
BOARD OF DIRECTORS OF THE
COOK COUNTY HEALTH AND HOSPITALS SYSTEM

AUGUST 12, 2009

ATTENDANCE

Present: Chairman Warren L. Batts; Vice Chairman Ramirez and Directors David A. Ansell, MD, MPH; Hon. Jerry Butler; David Carvalho; Quin R. Golden; Benn Greenspan, PhD, MPH, FACHE; Sister Sheila Lyne, RSM; and Heather E. O'Donnell, JD, LLM (9)

Director Andrea Zopp (attended telephonically) (1)

Absent: Director Luis Muñoz, MD, MPH (1)

Also Present: David Barker, MD – Chief Medical Officer, Ruth M. Rothstein CORE Center of Cook County; Pitt Calkin – Interim Chief Financial Officer, Cook County Health and Hospitals System; Albert De La Cruz – MedAssets; Patrick T. Driscoll, Jr. – Deputy State's Attorney, Chief, Civil Actions Bureau, Office of the State's Attorney; William T. Foley – Chief Executive Officer, Cook County Health and Hospitals System; Hon. Bridget Gainer – Cook County Commissioner; Maurice Lemon, MD – Chief Medical Officer, John H. Stroger, Jr. Hospital of Cook County; Jeff McCutchan – Supervisor, Transactions and Health Law Division, Office of the State's Attorney; John M. Raba, MD – Interim Chief Medical Officer, Cook County Health and Hospitals System; Elizabeth Reidy – General Counsel, Cook County Health and Hospitals System; Jonathan Rothstein – Deputy Bureau Chief, Bureau of Human Resources of Cook County; Gretchen Ryan – Project Manager, MedAssets; Deborah Santana – Secretary to the Board, Cook County Health and Hospitals System

Ladies and Gentlemen:

Your Board of Directors of the Cook County Health and Hospitals System met and held their annual meeting pursuant to notice on Wednesday, August 12, 2009 at the hour of 7:30 A.M. at Stroger Hospital, 1901 W. Harrison Street, in the fifth floor conference room, in Chicago, Illinois.

Your Board of Directors has considered the following items and upon adoption of this report, the recommendations follow.

Deborah Santana, Secretary to the Board, called the roll of members and it was determined that a quorum was present.

Chairman Batts indicated that Director Zopp was not physically present at the meeting, but would be attending the meeting via teleconference call.

Director Zopp confirmed her presence via teleconference call.

Director Butler, seconded by Director Lyne, moved to allow Director Zopp to participate as a voting member in the meeting telephonically. THE MOTION CARRIED UNANIMOUSLY.

PUBLIC COMMENTS

Chairman Batts asked the Secretary to call upon the registered speakers.

The Secretary called upon the following registered public speaker:

1. George Blakemore Concerned Citizen

APPROVAL OF THE MINUTES OF THE MEETING OF THE COOK COUNTY HEALTH AND HOSPITALS SYSTEM BOARD OF DIRECTORS OF THURSDAY, JULY 16, 2009

Director Greenspan, seconded by Director Lyne, moved to approve the minutes of the meeting of the Cook County Health and Hospitals System Board of Directors of Thursday, July 16, 2009. THE MOTION CARRIED UNANIMOUSLY.

REPORT FROM SYSTEM BOARD CHAIRMAN WARREN L. BATTS

Chairman Batts stated that he had nothing to report at this time.

DISCUSSION OF LABOR AND EMPLOYMENT MATTER

Director Butler, seconded by Director Golden, moved to recess the regular session and convene into closed session, pursuant to an exception to the Open Meetings Act, 5 ILCS 120/2(c)(2), et seq., which permits closed meetings for consideration of "collective negotiating matters between the public body and its employees or their representatives, or deliberations concerning salary schedules for one or more classes of employees." THE MOTION CARRIED UNANIMOUSLY.

Chairman Batts declared that the closed session was recessed. The Board reconvened into regular session.

REPORT FROM THE SYSTEM
CHIEF EXECUTIVE OFFICER WILLIAM T. FOLEY

Mr. Foley presented information regarding the following (Attachment #1):

Revised Chief Executive Officer's 90 Day – 6 Month – 1 Year Plan for the Cook County Health and Hospitals System

Mr. Foley briefly reviewed the plan. He stated that Navigant Consulting's performance improvement assessment will probably not be completed until mid to late September, as they are having difficulties gathering the data that is needed. He indicated that the Board should be receiving a thorough update from Navigant at their meeting on August 26th.

With regard to the status of filling leadership positions, Mr. Foley informed the Board that the position of Chief Compliance Officer has been filled. Cathy Bodnar, who previously worked for seven years as Director of Compliance at Northwestern, will be starting in September. He added that a Chief Information Officer has been hired; information on the individual's identity will be released at a later date.

Briefing on Potential Integration of OB/Gyn Residency Program

Mr. Foley stated that Dr. John Raba, System Interim Chief Medical Officer and Dr. Maurice Lemon, Chief Medical Officer of John H. Stroger, Jr. Hospital of Cook County, would be presenting the Board with a briefing on a time-sensitive issue.

Dr. Lemon explained that Northwestern and our own obstetrics and gynecology leadership have forwarded the outlines of a proposal to consider, to completely integrate the OB/Gyn residencies between the two institutions. Currently, there is an affiliation agreement under which their residents come here and our residents go there. This would represent a move beyond that, to a complete integration of those two programs. A letter is being drafted to the Accreditation Council of Graduate Medical Education (ACGME) on this subject, the idea is to start in July 2010. Because of the lead time in recruiting classes, a letter to apply for next July would have to be received within a week or so. He added that the System has successfully integrated in the past, providing the example of Rush and the Surgery Residency Program.

Dr. Lemon continued by stating that a contract would still need to be drafted and brought before the Board for approval once the details were worked out. But for now, the letter being drafted to ACGME will have the System's commitment to not recruit the first year class next year in OB/Gyn.

The Board reviewed and discussed the information. Dr. Lemon stated that he could forward the draft letter to the Board for their review.

Director Carvalho stated that he would like to pose a couple of questions, which did not need to be answered at this meeting. First, the Board will want to know whether Northwestern is paying the System's doctors beyond what the System is paying them in connection with those activities. Second, because of the nature of obstetrics, when a patient is a returning client for seven or eight months, there has always been a continuity of care issue when you have a residency program providing for that care. Pregnant women coming to Stroger Hospital may see a different doctor every time they visit. He requested that they try to build something into the agreement to address this concern.

Mr. Foley stated that at this time, they are requesting the Board's input and support to proceed with the letter and development of a proposal.

Director Lyne, seconded by Director Greenspan, moved to support the Chief Executive Officer and medical staff's actions to negotiate this transaction, with the understanding that the final agreement will be brought back for the Board's approval. THE MOTION CARRIED UNANIMOUSLY.

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REPORT FROM THE SYSTEM
INTERIM CHIEF MEDICAL OFFICER JOHN RABA, MD

Dr. Raba presented information regarding the following (Attachment #2):

Integration of System-wide Clinical Services

Dr. Raba pointed out that since the last time he reported on the subject, two additional departments have been integrated System-wide.

Collaborations within and outside the System

Dr. Raba informed the Board that they will have a report at their meeting of August 26th on the System's ongoing efforts with regard to preparedness for H1N1 (Swine Flu).

Single Medical Staff Bylaws

Dr. Raba stated that efforts continue on the draft of the single medical staff bylaws. It is expected that the final draft will be presented to the three hospital bylaws committees by September 1, 2009. He hopes to have everything finalized, after review and approval by the appropriate entities, by late Fall in 2009.

Physician Salary Issue

Dr. Raba provided an update on an issue that came up in the Human Resources Committee with regard to physician salary inequity corrections. He was directed to create a plan that would equalize salaries for similar specialties and primary care providers. The plan was created and implemented; changes were made in the payroll system and these salary adjustments will begin to be received by the providers on August 26th.

Accountability and Productivity

With regard to dual employment standards for the clinical leaders, these have been finalized, and compliance by the Department Chairs is being implemented. By August 15th, Department Chairs with outside ongoing practices are to have agreed upon a plan to eliminate their practices by no later than December 1st.

COMMITTEE REPORT

Human Resources Committee……..……Meeting of 7-24-09

Director Zopp, seconded by Director Butler, moved to approve the Report of the Human Resources Committee for the meeting of July 24, 2009. THE MOTION CARRIED UNANIMOUSLY.

COMMITTEE REPORT

Finance Committee……..…….Meeting of 7-24-09*
* note: Contracts and Procurement Items, as amended, were approved by the Finance Committee at this meeting:

Director Carvalho, seconded by Vice Chairman Ramirez, moved to approve the Report of the Finance Committee for the meeting of July 24, 2009. THE MOTION CARRIED.

Director Greenspan recused himself and voted PRESENT on request number 15 contained within the Report under the Contracts and Procurement Items.

COMMITTEE REPORT

Audit and Compliance Committee……...……..…….Meeting of 7-28-09

While presenting the report, Director Greenspan noted that by approving this report, the Board is accepting the recommendations of the Audit and Compliance Committee for priorities in the Internal Audit Plan.

During the discussion of the report, the subject of indirect cost recovery from federal grants arose. Director Ansell referenced Hektoen as a method of getting grants into the institution; he inquired whether the System has recovered indirect costs from these grants as a pass-through from Hektoen. Dr. David Barker, Chief Medical Officer of The Ruth M. Rothstein CORE Center of Cook County, responded that, as the largest user of Hektoen, he did not believe that the County recovers indirects. Director Carvalho added that he understands that the Audit and Compliance Committee intends to address this subject in a future meeting.

Director Greenspan, seconded by Director Butler, moved to approve the Report of the Audit and Compliance Committee for the meeting of July 28, 2009. THE MOTION CARRIED UNANIMOUSLY.

COMMITTEE REPORT

Quality and Patient Safety Committee……...…….Meeting of 7-28-09*
* note: Medical Staff Appointments/Re-appointments/Changes were approved by the Quality and Patient Safety Committee at this meeting.

Director Ansell, seconded by Director Butler, moved to approve the Report of the Quality and Patient Safety Committee for the meeting of July 28, 2009. THE MOTION CARRIED UNANIMOUSLY.

COMMITTEE REPORT

Finance Committee…….……Meeting of 8-07-09*
* note: Contracts and Procurement Items, as amended, were approved by the Finance Committee at this meeting:

Director Carvalho, seconded by Director Lyne, moved to approve the Report of the Finance Committee for the meeting of August 7, 2009. THE MOTION CARRIED.

Director Carvalho recused himself and voted PRESENT on request numbers 3 and 5 contained within the Report under the Contracts and Procurement Items.

APPROVAL OF A RESOLUTION AUTHORIZING THE CHIEF EXECUTIVE OFFICER TO ENTER INTO AND EXECUTE NON—PROCUREMENT CONTRACTS

WHEREAS the Ordinance establishing the Cook County Health and Hospitals System ('System"), Code of Ordinances of Cook County, Article IV, Section 38-80(d), provides that the System's Board of Directors ("System Board") has the power to authorize the Chief Executive Officer to enter into contracts, execute all instruments, and do all things necessary or convenient in the exercise of the System Board's powers and responsibilities; and

WHEREAS the System Board previously adopted a Procurement Policy which provides, in relevant part, that all Contracts for Purchases of supplies, material, equipment and non-Professional and Managerial Services of $100,000.00 or more, or Contracts for Professional and Managerial Services of $25,000.00 or more, shall be approved by the System Board and executed by the System's Chief Executive Officer and Chief Financial Officer; and that all other Purchases shall be approved by the Chief Executive Officer or his or her designee and executed as set forth in the procedures promulgated pursuant to this Policy; and

WHEREAS the System Board wishes to authorize the System's Chief Executive Officer to execute contracts, in addition to those contracts addressed in the Procurement Policy ("non-procurement contracts"), without seeking additional System Board approval.

THEREFORE, BE IT RESOLVED, that the System Board grants the System's Chief Executive Officer or his or her designee the authority to negotiate, approve and execute non-procurement contracts necessary or convenient in the exercise of the System Board's powers and responsibilities.

BE IT FURTHER RESOLVED, that the Chief Executive Officer shall provide a list of any contracts executed pursuant to this resolution to the appropriate System Board committee at its next regularly scheduled meeting.

Elizabeth Reidy, General Counsel for the Cook County Health and Hospitals System, presented the proposed Resolution and provided a brief summary of the item.

Director Ansell, seconded by Director Lyne, moved to approve the Resolution Authorizing the Chief Executive Officer to Enter Into and Execute Non-Procurement Contracts. THE MOTION CARRIED UNANIMOUSLY.

APPROVAL OF PATIENT ACCOUNTING POLICIES

Gretchen Ryan, of MedAssets, presented the proposed patient accounting policies, entitled Revenue Cycle Policies (Attachment #3).

Ms. Ryan noted that page three of the handout listed all of the policies before them, with the exception of the Uninsured Patient Discounts. That policy is pending legal review, and is not being presented for their consideration at this time.

Ms. Ryan highlighted the CareLink program, which is what would currently be considered the Limit of Liability program. Going forward, it is a financial assistance program for Cook County residents at or below 450% of the federal poverty guidelines.

The Board discussed the proposed $10.00 co-pay amount; Director Carvalho inquired whether there was a difference in co-pays for a four-day inpatient stay compared to a 15-minute outpatient visit.

Albert De La Cruz, of MedAssets, responded that the $10.00 co-pay is for medical services, regardless of whether it is relating to those received as an inpatient or outpatient, or relating to length of stay. Ms. Ryan provided an example; if a patient sees three separate clinics in one location on one given day, the patient will have a $10.00 co-pay for each clinic visit, totaling $30.00 in co-pays for that given day.

In response to questions from Director Ansell regarding the underinsured, Ms. Ryan stated that underinsured patients served by the System would need to have insurance with a company that the System participates with. Additionally, each contract that the System has with these insurance companies needs to be reviewed to see if the co-pay can be waived.

Director Carvalho noted that consistency with policies across the System is important. He requested information on what the local federally-qualified health care centers charge for co-pays.

Director Greenspan inquired as to the projected implementation date. Ms. Ryan responded that implementation of these policies needs to be staggered; it is paired with the financial counseling initiative. The first one would be tied to the October 1st goal of inpatient financial counseling across the System. The timeline for outpatient financial counseling was January 1, 2010.

It was stated that the Board would receive a report on the feedback from the medical staff after their review of the policies.

Director Greenspan, seconded by Director Lyne, moved to approve the proposed Revenue Cycle Policies. THE MOTION CARRIED UNANIMOUSLY.

REPORT FROM CCHHS AD HOC WORKING GROUP ON MEDICAL SCHOOL RELATIONSHIPS

Director Lyne presented a report from the ad hoc Working Group on Medical School Relationships. She stated that they are continuing to look at the costs. They are starting to look at the Loyola relationship; there is a cost of $2.6 million for the Family Practice Program for services between Loyola and Provident.

Director Lyne informed the Board that upon review of the Family Practice Residency Program with St. Anthony's, it was found that the System was not billing St. Anthony's for these services. She added that System staff immediately began to address this issue.

Director Lyne, seconded by Director Ansell, moved to accept the report of the ad hoc Working Group on Medical School Relationships. THE MOTION CARRIED UNANIMOUSLY.

UPDATE FROM AD HOC STRATEGIC PLANNING COMMITTEE

Director Golden provided an update from the ad hoc Strategic Planning Committee. She stated that they continue to meet every week to talk about the progress made with the planning process. They are still in the discovery phase, in which John Abendshein's group is gathering external information to get feedback on the System's strengths and weaknesses. They are expecting to start getting some of the preliminary findings from Mr. Abendshein in the next couple of weeks. She referenced the remaining town hall meetings (Attachment #4).

Chairman Batts suggested that for the town hall meetings, in addition to showing the System's mission, information such as three-year cost trends should be provided, also.

Mr. Foley announced that there will be a seventh town hall meeting set, specifically for the Hispanic/Latino community.

With regard to meetings of the Board for strategic planning, Mr. Foley stated that there will be a three-hour Board meeting dedicated to the strategic planning process on September 18th. Additionally, a retreat is planned for early October; the Board will be polled for their availability to set that date.

Mr. Foley stated that at the retreat, they would have the framework for the plan, which would be reviewed with the Board in detail. Assuming agreement is reached at the retreat, during the month of October there will be various meetings with the constituencies throughout the System and County.

There will be a second round of town hall meetings in the month of October. The goal is to bring the plan back to the Board for official action at the November 5th meeting.

DISCUSSION OF LITIGATION MATTERS

Director Greenspan, seconded by Director Butler, moved to recess the regular session and reconvene into closed session, pursuant to an exception to the Open Meetings Act, 5 ILCS 120/2(c)(11), which permits closed meetings for consideration of "litigation, when an action against, affecting or on behalf of the particular public body has been filed and is pending before a court or administrative tribunal, or when the public body finds that an action is probable or imminent, in which case the basis for the finding shall be recorded and entered into the minutes of the closed meeting." THE MOTION CARRIED UNANIMOUSLY.

Chairman Batts declared that the closed session was adjourned. The Board reconvened into regular session.

ADJOURNMENT

Director Golden, seconded by Director Carvalho, moved to adjourn. THE MOTION CARRIED UNANIMOUSLY AND THE MEETING ADJOURNED.

Respectfully submitted,
Board of Directors of the
Cook County Health and Hospitals System

XXXXXXXXXXXXXXXXXXXX
Warren L. Batts, Chairman

Attest:

XXXXXXXXXXXXXXXXXXXXX
Deborah Santana, Secretary

ATTACHMENT #1

WILLIAM T. FOLEY
CCHHS CEO
90 DAY—6 MONTH—1 YEAR PLAN
REVISED—AUGUST 7, 2009

9/1/09:

Task	Status
Complete Navigant Consulting Performance Improvement Assessment	Due to difficulties in collecting data, anticipated completion date delayed until 9/30/09.
Initiate ERP installation	Contract with ACS for ERP installation approved by CCHHS Board on 6/26/09. Installation in process.
Revise MedAssets agreement	Contract Amendment approved in Finance Committee Report of 6/30/09 and by the CCHHS Board on 7/16/09.
Establish Office of Performance Improvement and hire a Director as an interim, full-time position for a period of no longer than 1 year.	Jeanene Johnson assumed position on 6/29/09.
Hire Director of Human Resources	Deborah Tate assumed position on 7/13/09.
Hire Director of Public Relations/Communications	Lucio Guerrero assumed position on 7/6/09.
Hire Chief Compliance Officer	Cathy Bodnar to assume position on 9/8/09.
Hire Chief Clinical Officer	Roz Lennon assumed position on 7/27/09.
Hire General Counsel	Elizabeth Reidy to assume position on 8/10/09.
Complete Solucient FTE benchmarking study and implement Phase 1 reduction-in-force.	Benchmarking Study complete. Navigant Consulting to assist in implementation.
Select Group Purchasing Organization (GPO) and finalize agreement.	UHC/Novation contract as GPO approved in the Finance Committee Report of 5/29/09 and by the CCHHS Board on 6/4/09. Agreement in process of being finalized with assistance of Navigant Consulting.

12/1/09:

Task	Status
Complete Phase 1 of performance improvement project with focus on revenue cycle management, labor productivity, non-labor productivity, and physician services.	
Complete Phase 1 of ERP installation: financial reporting/general ledger.	
Implement Phase 2 reduction-in-force.	
Hire CCHHS CFO.	Michael Ayres to assume position on 9/1/09.
Hire CCHHS CMO.	Recruitment in process.
Hire CCHHS CIO.	Offer made and accepted. Candidate to assume position on 9/8/09.

Finalize and approve CCHHS Strategic Plan.	
Finalize and approve CCHHS 3-Year Financial Plan.	

6/1/10:

Task	**Status**
Complete Phase 2 (final phase) of performance improvement project including staff education and training.	
Complete Phase 2 of ERP installation: human resources, payroll, productivity, and supply chain.	
Implement Phase 1 strategic plan strategies.	

ATTACHMENT #2

Interim System CMO Report
CCHHS Meeting
August 12, 2009

Integration of System-wide Clinical Services

- 20 clinical departments, divisions, and programs have now been designated as system-wide entities. Since the last CMO report system chairs of Otolaryngology and Family Planning have been added to Adult Endocrine, Breast Cancer, Emergency Medicine, Family Practice, Gastroenterology, Hematology-Oncology, Infectious Diseases, Neurology, OB-Gyn, Ophthalmology, Pain, Pediatrics, Palliative Care, Psychiatry, Pulmonary/Critical Care, Radiology Rehabilitation and Physical Medicine, Surgery, and Urology. Cardiology, Rheumatology, Dermatology, and Infection Control are in process. Searches for System Chairs of Anesthesiology, Laboratory/Pathology, and Medicine are in various stages of completion.
- Respiratory therapy services at Stroger, Provident, and Oak Forest Hospitals have been placed under the administration of the system Division of Pulmonary/Critical Care. Respiratory Therapy had been the only clinical technical service in the CCHHS that did not report to clinical leadership.
- Each department is submitting metrics to evaluate clinical services across the CCHHS.
- The job description for System-wide Clinical Chairs has been finalized and will be presented to the HR committee.

Collaborations within and outside the System

- Radiology staffing levels at Provident Hospital have been assessed and opportunities to expand on-site radiologist coverage, maximize productivity, and minimize utilization of contracted radiologist hours have being identified. Annual savings to the CCHHS will be >$400,000.
- OB-Gyn has identified two Stroger physicians who will provide OB-Gyn consultation services at Oak Forest Hospital. They are completing their OFH credentials applications.
- Gastroenterology services staffed by a recent grad of the Stroger Hospital GI fellowship program has started at Oak Forest Hospital where he will provide inpatient and outpatient consultations.
- Efforts are in process to allow non-CCHHS FQHC community health center partners to have access to medical information in Cerner on shared patients. This arrangement will be discussed at the IT taskforce meeting on 8/19/09.
- Discussions have been initiated with the University of Chicago concerning opportunities for collaborative relationships with Provident Hospital concerning a range of patient care services and with ACHN concerning U of C's 87th Street clinic.
- The hospital Quality Directors long with the System CMO, CCO, and COO are developing an organizational structure that unifies the approach to quality and patient safety at both the local affiliates and throughout the CCHHS

Single Medical Staff Bylaws

- The State's Attorneys and representatives of the CMOs continue to work on the final draft of unified System medical staff bylaws. It is firmly anticipated that the draft of the single bylaws will be presented to the three hospital bylaws committees by September 1, 2009. The bylaws committees will be then given 6 weeks to separately and jointly review the document. The States Attorneys will review and incorporate revisions recommended by the bylaws committees and CMOs into a final document that will be

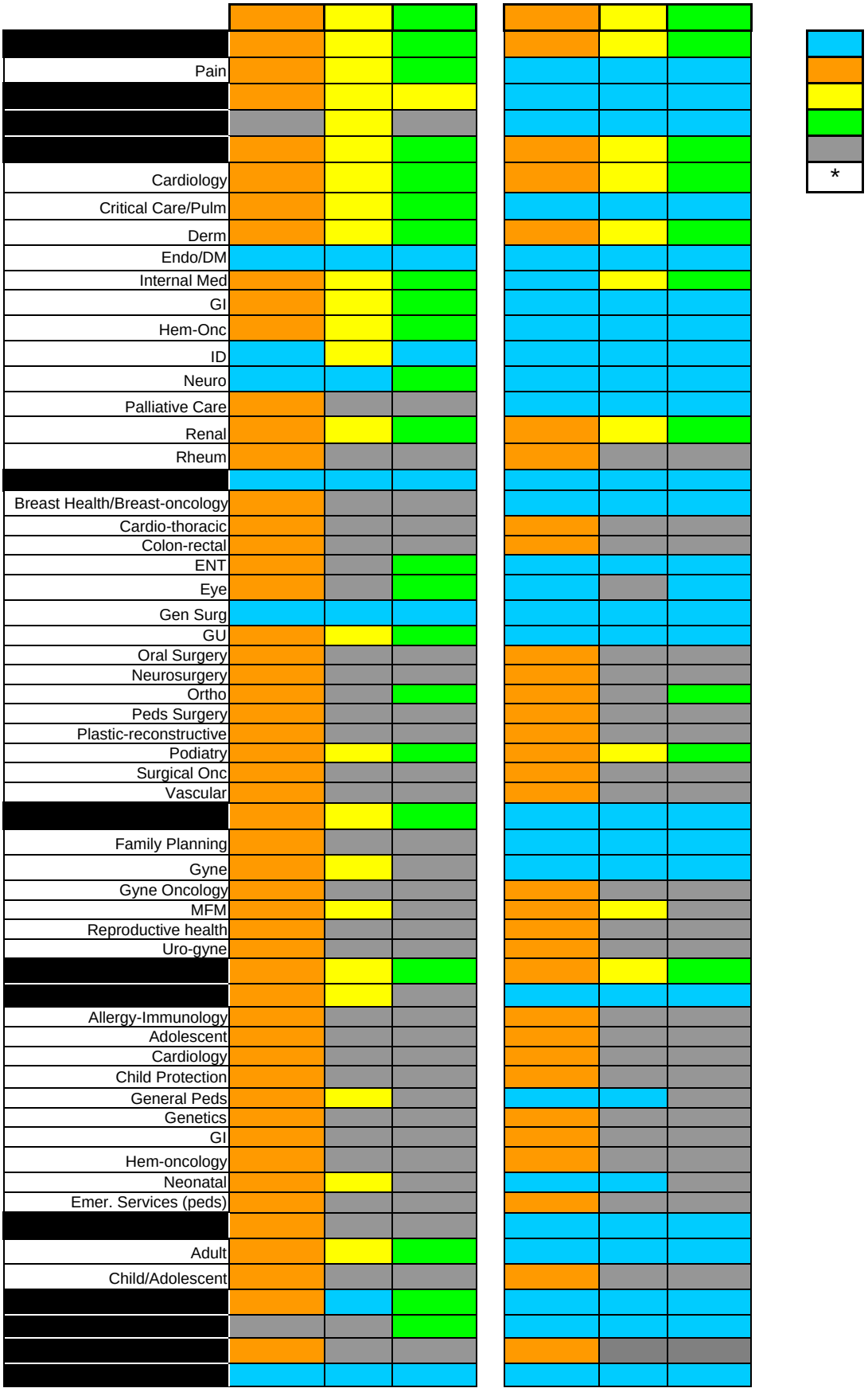
presented to the CCHHS Board. Once approved by the CCHHS, the new bylaws will be scheduled to be voted upon by the medical staffs of the System. It is anticipated that draft will be ready for vote in the late Fall, 2009.

Physician Salary Issue

- The physician salary adjustments that addressed inequities exacerbated by the new CCB physician salary scale have been entered into the payroll system and will be begin to be received by the providers on August 26, 2009.
- A comparative study of current CCHHS salary levels for primary care and specialty physicians has been initiated using benchmarks established by the AAMC and the SullivanCotter Physician Reimbursement Survey.

Accountability and Productivity

- System-wide metrics that are facility, center, and provider specific continue to be identified by system chairs.
- Departmental and Divisional accountability expectations are being audited at all facilities in the CCHHS.
- Dual employment standards for clinical leaders have been finalized. Compliance by Department chairs with these standards is being implemented. By 8/15/09, Department Chairs with outside ongoing practices are to have agreed upon a plan to eliminate their practices by no later than 12/1/09


Pain
Cardiology
Critical Care/Pulm
Derm
Endo/DM
Internal Med
GI
Hem-Onc
ID
Neuro
Palliative Care
Renal
Rheum
Breast Health/Breast-oncology
Cardio-thoracic
Colon-rectal
ENT
Eye
Gen Surg
GU
Oral Surgery
Neurosurgery
Ortho
Peds Surgery
Plastic-reconstructive
Podiatry
Surgical Onc
Vascular
Family Planning
Gyne
Gyne Oncology
MFM
Reproductive health
Uro-gyne
Allergy-Immunology
Adolescent
Cardiology
Child Protection
General Peds
Genetics
GI
Hem-oncology
Neonatal
Emer. Services (peds)
Adult
Child/Adolescent
*

ATTACHMENT #3

MedAssets
flexible approach. custom solutions.

Cook County Health and Hospitals System

Revenue Cycle Policy Approval Request

August 12, 2009





MedAssets Representatives

- Gretchen Ryan – Project Director
- Ernest DeLaCruz – Senior Project Manager
- Dorothy DiCarlo – Senior Project Manager
- Victor Zamora – Project Manager

Board Workgroup

- Sr. Sheila
- Heather O'Donnell
- Chairman Batts
- David Small
- Pitt Calkin
- Bill Foley
- Mercy Hospital CFO
- University of Chicago CFO

Policies List

Policy Number	Policy Name
RCFC01	CareLink Financial Assistance Program
RCPAS01	Accident Data Collection
RCPAS02	Bed Management
RCPAS03	Emergency Department Point of Service Collection
RCPAS04	General Registration
RCPAS05	Insurance Verification/Authorization Policy
RCPAS06	Pre-Registration Add-on
RCPAS07	Identity Theft Preventive Program
RCPAS08	Patient Payment Financial Clearance
RCPAS09	Pre-Registration
RCPAS10	Quality Assurance
RCPAS11	Scheduling
RCPAS12	Timely Insurance Information Requirements
RCPAS13	Consent for Treatment of Minors
RCPFS01	Patient Accounts Contractual Allowances
RCPFS02	Processing Credit Balances
RCPFS03	Patient Accounts Follow Up and Collections, Third Party
RCPFS04	Administrative and General
RCPFS05	Third Party Billing
RCPFS06	Self Pay Time Payments (Payment Plans)
RCPFS07	Uninsured Patient Discounts – Pending Legal Review

CareLink Overview

- **Provide financial assistance to qualified Cook County residents with income at or below 450% of the federal poverty guidelines as published annually in the federal register.**
- **Replaces current LOL program.**
- **Complies with all state laws and precedent set by the Illinois Department of Healthcare and Family Services (IDHFS).**

CareLink Eligibility

- **A patient is eligible to apply for assistance for medically necessary services under the CareLink program if they are:**
  - Residents of Cook County;
  - Have an annual income equal to or less than 450% of federal poverty guidelines;
  - Uninsured;
  - Underinsured (insurance must be considered in network with CCHHS)
- **Applicants must meet <u>all</u> eligibility requirements**

CareLink Non-Cook County Residents

Persons not considered Cook County residents include the following persons. Non-resident applicant:

- Resides outside of the boundaries of Cook County limits.
- Moves into Cook County for the sole purpose of obtaining medical care through a charity-based program and does not establish the 30-day residency requirement.
- Is an inmate, patient or resident of a school or institution operated by a state or federal agency.
- Is age 18–22, a college student, and primarily supported by parents/guardians whose residence is located outside Cook County. For the purposes of eligibility “primarily supported” is defined as greater than 50% of their living needs; whether paid directly to the applicant or as “in-kind” (on behalf of the applicant).

CareLink Eligibility Periods

- **12-month Eligibility Period**
- **Retroactive Eligibility up to 12 months**
- **Eligibility Periods Based on Medical Statement**

CareLink Pharmacy Benefit

- **Current State**
  - All CCHHS patients served regardless of insurance or ability to pay

- **Future State**
  - All CCHHS patients with insurance will qualify for use
  - All CCHHS patients enrolled in the Carelink program will qualify for use
  - All CCHHS patients considered straight self pay will be directed to community retail pharmacy locations.

Carelink Financial Responsibilities

- **$10 co-payment per medical/clinical service**
- **$4 co-payment per 30-day prescription**

Patient Payment Financial Clearance Overview

- **Required for all non-emergent services**
- **Includes identification of patient liability prior to or at the time of service**
- **Patient notification of liability**
- **Patient required to make satisfactory payment arrangements prior to service being rendered**
  - Patients will not be refused treatment based upon clinical evaluation

Other Policies

- **Patient Discount Policy**
  - Pending legal review

Cook County Health & Hospitals System		**Financial Counseling Services**
Policy Title: CareLink Financial Assistance Program Policy & Procedure		**Policy Number**:RCFC01
Date of Original Policy: 10/1/2009 **Revised:** N/A	☑ Core Policy ☐ Area Specific Policy	**Pages:** 27

Purpose:
To provide the guidelines for accessing financial assistance through CareLink for residents of Cook County.

Scope:
The Cook County Health & Hospitals System mission is to provide a full range of high quality services to all the patients it serves. CCHHS will sponsor and administer a system wide charity program, known as CareLink, herein referred to as "CareLink." CareLink is a program designed to assist those patients with income at or below 450% of the federal poverty guidelines as published annually in the Federal Register. CareLink is a financial assistance program for patients of CCHHS. A patient is eligible to apply for assistance for non-elective medical services under the CareLink program if they are:

- Residents of Cook County;
- Have an annual income equal to or less than 450% of federal poverty guidelines;
- Uninsured;
- Underinsured (have public or private coverage that does not cover the cost of medically necessary care).

Patients who are potentially eligible for public coverage under Medicaid, Medicare or other public health care programs, must apply for such coverage to be eligible to apply for CareLink assistance. Medicare beneficiaries must be enrolled in Medicare Part D to receive assistance under CareLink and are also subject to asset limits. Individuals who decline employer-sponsored health insurance are not eligible to participate in the CareLink program. All patients receiving assistance under CareLink must pay a $10 co-pay at the time of each clinical service to contribute to the cost of their care. Assistance to qualified residents of Cook County is available for any of the health system' facilities. System facilities include John H. Stroger of Cook County, Oak Forrest Hospital of Cook County, Provident Hospital of Cook County, the Ambulatory & Community Health Network (ACHN), and the CORE center.

Procedure:
The following procedures are to be used in determining eligibility for the CareLink program.

Approved by:	Date:

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Section I. Program Overview

Cook County Health & Hospitals System has the responsibility of providing medical care to the indigent residents of Cook County, Illinois. CareLink is a healthcare assistance program intended to provide financial assistance to qualified Cook County residents. This document establishes the requirements to determine eligibility for the CareLink program.

Program Guidelines

The CareLink Policy will comply with all state laws and precedent set by the Illinois Department of Healthcare and Family Services (IDHFS).

CareLink eligibility will be administered by the financial counseling services department and patient registration operations unit. CCHHS will utilize federal poverty guidelines as published annually in the Federal Register as the basis for income eligibility thresholds.

Income eligibility is based on the following Federal Poverty Income Levels (FPIL) as follows:

- Individuals with an annual income equal to or less than 250% of the Federal Poverty guidelines as established in the Federal Register annually are eligible for a 100% discount of total charges.

- Individuals with an annual income greater than 250% of the federal poverty level but equal to or less than 350% of the current years Federal Poverty guidelines as established in the Federal Register annually are eligible for a 50% discount of total charges.

- Individuals with an annual income greater than 350% of the federal poverty level but equal to or less than 450% of the current years Federal Poverty guidelines as established in the Federal Register annually are eligible for a 25% discount of total charges.

- Individuals with an income above 450% are not eligible for assistance under the CareLink program.

Criteria Evaluated

Applicants must meet **all** eligibility requirements to be eligible. Program eligibility determinations are based on analysis of the following criteria:

- Established Cook County Residence
- Third Party Funding Sources
- Identification
- Household Composition
- Income

- Resources (as required by Medicare regulations for indigence)

It is the applicant's responsibility to present required documentation to substantiate the criteria above. Applicants who refuse to provide this documentation are not eligible. Applicants will be made aware that independent verification is a part of the eligibility process. This includes the use of all available technology to include, but not limited to the use of credit reporting bureaus. Applicants are **required to provide written attestation** to the validity and accuracy of information provided.

Reasonable Judgment Eligibility Decisions

Every effort will be made to determine an applicant's eligibility based on policies and procedures in this document as well as those in IDHFS TANF guidelines, Medicaid Eligibility policy and Illinois statute. In those instances where a clearly defined policy does not exist, CCHHS recognizes and encourages the use of a "Reasonable Judgment Rule" to reach a decision about an applicant's CareLink eligibility. The "Reasonable Judgment Rule" is addressed in this policy manual.

Patient Financial Obligations

All applicants enrolled in the CareLink program are required to make a ten dollar ($10.00) co-payment at the time of each clinical service. The ability or inability to meet the program's patient financial obligations does not affect eligibility or ability to receive healthcare services. However, failure to satisfy this financial obligation will result in enforcement of CCHHS' standard collection efforts.

Pharmacy Financial Obligations

Use of CCHHS pharmacies is limited to patients enrolled in the CareLink program. Prescriptions must be written by a CCHHS staff physician. All applicants enrolled in the CareLink program are required to make a four dollar $4.00 co-payment per prescription prior to the medication(s) being dispensed. All prescriptions will be limited to a 30-day supply per co-payment. Patients who do not have the ability to make the necessary co-payment will only receive a 14-day supply of the prescribed medications on a one-time basis.

Right to Appeal Process

Every applicant will be afforded the right to appeal any decision related to program eligibility. The applicant's right to appeal is addressed at the end of this policy.

Section II. Patient Identity Procedures

Documentation

In all cases, the applicant should be asked to provide a picture ID. If picture ID is not available, other forms of Identification are sufficient proof of applicant identification. The following may be used to establish the identity of the applicant. Patients are required to present two acceptable forms of Identification when applying for CareLink assistance.

Required forms of ID: 1 item from list A, or 2 items from list B.

List (A) Photo Identification

- Valid Illinois State Department of Public Safety photo ID
- Valid domestic or foreign driver's license
- Military ID
- Passport
- Student picture ID
- Employee picture identification card
- Foreign voter's registration with picture
- Worker's permit identification with picture

List (B) Other Forms of Identification

- Immigration documentation
- Social Security card
- SSI/RSDI award letter
- Birth certificate
- Baptismal record
- Voter registration card
- Wage Stubs
- Referral letters from state or local agencies on agency letterhead. (Examples: Any local entity such as a church, hospital, shelter, a court or government agency.)

Documentation – Catastrophic Hospitalization

Applicants who are hospitalized and are unable to provide customary identification because of an incapacitating medical condition are permitted other alternative sources of proof. Specifically, a patient who has an incapacitating medical condition (for example, comatose) and is known or presumed to be homeless can use the following as evidence of identification:

- Review of information in current medical chart
- Review of medical information from a previous admission
- Coordination of "Patient Valuables" review

Section III. Cook County Residency Requirements

Cook County Residents

Persons applying for CareLink assistance must reside in Cook County at the time of treatment, and at the time of application. An applicant can be considered as living in Cook County in the following situations:

- Established residency in Cook County for at least (30) days prior to submission of an application for CareLink assistance.
- The applicant is living in a home or fixed place of residence located in Cook County.

- An applicant with no fixed residence declaring intent to remain and live in Cook County.
- Immigration status is not a factor in determining CareLink eligibility provided all other eligibility criteria is met.
- Patients residing at a domestic violence shelter in Cook County.

Temporary Absence from Cook County

An applicant can be absent from Cook County for any length of time. At interview or review, the applicant must be able to reasonably explain:

- The purpose for leaving Cook County;
- Whether the purpose was accomplished and, if not accomplished when the purpose will be completed.

Non-Cook County Residents

Persons not considered Cook County residents include the following persons:

- An applicant who resides outside of the boundaries of Cook County limits.
- An applicant who moves into Cook County for the sole purpose of obtaining medical care through a charity-based program and does not establish the 30-day residency requirement.
- An applicant who is an inmate, patient or resident of a school or institution operated by a state or federal agency.
- An applicant who is age 18–22, a college student, and primarily supported by parents/guardians whose residence is located outside Cook County. For the purposes of eligibility "primarily supported" is defined as greater than 50% of their living needs; whether paid directly to the applicant or as "in-kind" (on behalf of the applicant).

Residency Documentation

Accepted Proof

All residency documentation must be in the name of the applicant or a member of the household unit (as defined in Section IV – Household Composition of this policy). The documentation must contain the address used or declared by the applicant to establish residency.

Requirement at application: At least 1 of the following items must be used to verify Cook County residency:

Proof of residency

- Mortgage statement dated within 30 days of the interview date
- Current lease agreement, deed, or sales contract for home purchase
- Utility receipts dated within 30 days of the interview date
- Public or private school enrollment records
- Receipt of payment of property tax
- Written referral letter from a shelter on letterhead
- Documentation of release from a Department of Corrections Facility to a Cook County address.

- Award letter from a federal or state agency (for example, Disability Award or Food Stamps) dated within previous 60 days.
- Voter registration card
- Automobile registration
- Business mail addressed to the applicant or member of the household unit

No Fixed Residence, Homeless

Some applicants will not have any documented verification of Cook County residency. In these situations the applicant must be able to reasonably explain the following during interview or review:

- Why there is no acceptable verification of Cook County residence available, and/or
- The living arrangements including homeless status

An applicant is considered a resident of Cook County for purposes of the CareLink Policy if the financial counselor can document good reason for no acceptable verification from the applicant. The financial counselor may deny the application if the applicant cannot reasonably explain the lack of verifiable proof.

The applicant must complete a "Declaration of Residency" form in situations where verifiable proof does not exist. The applicant must have also substantiated the reason for the lack of proof of residency. Financial counselors must document all efforts to verify residence when residence is difficult to verify due to unusual circumstances.

Residency Documentation Conflict

There are situations when an applicant states he/she is living at a certain Cook County residence (this includes living with a separate household due to certain circumstances) but address verification information demonstrates a conflict with the applicant's statement. In these instances the financial counselor will employ the procedures listed above in the **No Fixed Residence/Homeless** section of the policy.

Section IV. Household Composition Requirements

Definitions

Household

Eligibility is based on a household. A household, for purposes of determining CareLink eligibility, consists of a person living alone or persons living together where one or more individuals have a legal responsibility for the support of the others; even when more than one household resides together. The income of included household members is considered when determining eligibility.

Examples of a household include:

- Single adult 18 or older, not attending school
- Parents and minor children
- Legally married couples

- Common Law Marriage couples (couples living together and presenting themselves to the general public as a married couple)
- Domestic Partners

Excluded Household Members

Certain individuals living in an otherwise eligible household are not considered part of the household. This includes individuals who are receiving:

- Assistance to Needy Families (TANF)
- Supplemental Security Income (SSI)
- A household member not living in the household
- Incarcerated household members

The income of these household members is not considered when determining eligibility.

Minors as Household Members

A minor is any person who has not reached the age of 18, and is not, or has never been married. A household member's minority status is no longer in effect on the first day of the month following the month of;

- Their 18th birthday, or
- Their high school graduation. The household member must expect to graduate from high school before their 19th birthday.

Marriage, Separation & Divorce

Marriage: Two individuals who have made a legal or informal declaration of marriage. The marriage must hold to the legal, acceptable standard in the State of Illinois (at the time of application).

Separation: Two individuals who were previously married (legal and/or common-law) and who no longer reside in the same household.

Divorce: Two individuals who have dissolved the marriage agreement (legal and/or common-law).

Separate Households Living Together

Separate households living together include any individual (or family) living together with another household unit and that individual (or family) has no legal responsibility for members of the other household unit. In these instances the separate household person (or family) is not considered a part of household unit applying for CareLink assistance.

Examples of a separate household include:

- Single adults 18 or older living together
- Parents living with adult children
- Two legally married couples living together
- Domestic partners

The incomes of separate households living together are not counted when determining eligibility.

DOCUMENTATION

The following information can be used to document dependency status, marriage, separation, or divorce.

Dependency

Dependency can be established by presenting one (1) of the following documents containing the household member's name:

- Birth certificate
- Hospital or public health records of birth
- Church or baptismal record
- Local, state, federal government or military record
- School or day care records
- Court-ordered guardianship/conservatorship
- Immigration and Naturalization Service records

Marriage, Separation & Divorce

Marriage – Formal or Informal

- Marriage license
- Matrimonial or marriage certificate
- Verbal declaration of marriage
- Bureau of Vital Statistics Declaration of Informal Marriage Form
- Current joint income tax return

Separation

- Verbal declaration of separation from a spouse made at the beginning of the interview, otherwise both incomes should be used to determine eligibility
- School or day care records showing separate households for the parents or caretakers.

- Divorce decree

Section V. Income Guidelines

Income is any type of recurring payment that is received by any household member applying for assistance. Household income is verified and compared to the Federal Poverty Income Level chart to determine eligibility.

Types of Income

For CareLink assistance purposes there are two main categories of income that are to be assessed when determining eligibility. Types of income are "Countable Income" and "Exempt Income". The income of the applicant and applicable household members must be considered when determining eligibility. For the purposes of determining eligibility, income is either counted or exempt.

Countable Income

- Wages, Salaries, & Tips
- Commissions
- Bonus
- Alimony support
- Child support payments
- Retirement Survivors Disability Insurance (RSDI). These are benefits from the Social Security Administration
- Dividends, interest and royalties
- Pensions and annuities
- Veteran's Administration Benefits
- Education/training stipends (specified for living expenses)
- Worker's Compensation
- "Regular" cash support from family/others not living in the applicant household
- Income from rental property
- Farming income
- Odd jobs such as babysitting, cleaning houses, or mowing lawns, and day labor
- Lump Sum Payments (Counted only if received more than one in year, and only counts in the month received)

Exempt Income

Exempt income is income or payments received by the applicant or a household member but not counted towards the household's eligibility determination. Examples of Exempt Income may include:

- Supplemental Security Income (SSI) payments
- Dependent student/child earned income
- Temporary Assistance for Needy Families (TANF) or Foster Care
- Crime Victims Emergency Assistance

- Tax refunds
- Reimbursement of expenses (e.g. mileage, etc.)
- Employment income received by a full-time high school student
- Unemployment Insurance
- Lump Sum Payments received once per year.
- Irregular Payments from family and friends of $50.00 or less and not received regularly

Exempt income ***<u>is not</u>*** *counted* when determining eligibility.

Section VI. Income Determination Process

Calculating Income

Income determination for eligibility is based on verified **<u>gross</u>** monthly income. Not every applicant or household member receives income on a once monthly basis. Often a household's income must be converted from a non-monthly amount into a monthly amount.

Converting Income to Monthly Values
The following table lists the different conversion formulas to be used when converting income to a monthly amount.

If the applicant or household member receives income …	Then convert the income to a monthly amount by…
Weekly	Multiplying weekly average by 4.33
Every Other Week	Multiplying bi-weekly average by 2.17
Twice Monthly	Multiplying twice monthly average by 2
Once Monthly	Multiplying once monthly average by 1
Yearly (Self-employed)	Dividing previous tax years gross income by 12

Documenting Income

All household income, counted or exempted, must be verified and documented. An applicant's statement of income will not be accepted as income verification.

Employment Income Verification

An applicant's or household member's most recent paycheck stubs are the preferred method of verifying Employment Income. Acceptable forms of income verification may include:

Required at application:

Income Frequency	Pay Stubs Required
Weekly	Two (2) Payroll check stubs, dated within last 30 days, if employed full-time and paid weekly.
Every Two Weeks or Bi-monthly	Two (2) Payroll check stubs, dated within last 30 days, if employed full-time and paid every two weeks or bi-monthly.
Once Monthly	Two (2) Payroll check stubs, dated within last 60 days, if employed full-time and paid once monthly.
Employed Part-time or if hours vary	Four (4) Payroll check stubs, dated within last 60 days, if employed part-time or if hours vary.

Other forms of acceptable Income verification include:

Required at application, if payroll check stubs are not available or the applicant is not employed.

- Written verification from employer on company letterhead
- Child support payments or support verification letter
- Unemployment benefits statement or letter from the Illinois Dept. of Employment Security
- Alimony support records or cancelled checks
- Retirement, Survivors, Disability Insurance (RSDI) award letters
- Supplemental Security Income Award letters (SSI)
- Statement of dividends, interest and royalties
- Education/training stipends (specified for living expenses)
- Pensions and annuities statements
- Veteran's Administration Benefits
- Worker's Compensation letter
- Complete copy of prior years Federal tax filed

Section VII. Third Party Funding Sources

All patients applying must have a review of availability to third party funding (i.e., health insurance) completed as part of the eligibility assessment process. The review of health insurance availability is split into three broad categories: Access to Health Insurance, Enrollment in Health Insurance, and Other Funding Programs.

Third Party Funding Access

Enrollment in Employer-Sponsored Health Insurance

Applicants who are eligible, but not enrolled, in an employer-sponsored health plan at the time of application are not eligible for the CareLink assistance program.

Applicants who are enrolled in an employer-sponsored health plan at the time of application can be eligible for the CareLink assistance program if they meet all eligibility criteria, and their insurance plan is considered "In-Network" with CCHHS.

Enrollment in Other Funding Programs

Applicants who are enrolled in a funding program not sponsored by an employer such as Medicare and Medicaid at the time of application may be eligible for CareLink assistance as a secondary or tertiary funding source.

Other Funding Program Eligible Applicants

CCHHS, as a provider of care for indigent Cook County residents provides for patient admissions and outpatient visits using many different funding sources. Often, these programs may be limited in the scope of services funded for reimbursement. As such, the applicant can use CareLink Assistance together with another funding program for a healthcare service. An eligible patient should be reassessed anytime a third party funding source is identified and verified.

Section VIII. Resource Determination for Medicare Eligible Patients

Overview

Medicare recipients may be eligible for program coverage as secondary or tertiary coverage. However, Federal regulations require that Medicare providers follow certain guidelines when determining a patient's indigence. More specifically, Federal regulations state:

> *"The provider should take into account an applicant's total resources which would include, but are not limited to, an analysis of assets (only those convertible to cash and unnecessary for the applicant's daily living), liabilities, and income and expenses. In making this analysis the provider should take into account any extenuating circumstances that would affect the determination of the applicant's indigence."*

In addition, Medicare patients must also provide documentation related to personal assets at the time of application. The resource determination criteria in this section of the CareLink policy only apply to Medicare eligible applicants.

Resource Limits

A Medicare eligible applicant's total assets cannot exceed $5,000.00 at the time of the application. This amount is to be used for the household unit's combined assets; and not $5,000.00 per household member.

Evaluating Resources

There are two types of Resources, Liquid and Non-liquid. Liquid resources are resources that are readily available and can be converted to cash.

Liquid Resources

- Cash
- Checking & saving accounts
- Stocks
- Bonds.

Non-liquid Resources

- Items that generally take more than 30 days to convert to a liquid resource.
- Inaccessible
- Irrevocable trust funds,
- Property in probate,

*The applicant provides proof that the property cannot be sold with the consent of the owner others, and
*The owners of joint property refuse to sell or divide the property.

Fair Market Value

Fair market value (FMV) is the amount of money the sale of an asset would bring to the seller in normal market conditions. FMV is counted when determining eligibility. Use the average wholesale price of the asset to determine fair market value. If the applicant or household member states money is owed on an asset see directly below.

Equity Value

The equity value of a resource is counted when determining eligibility if the applicant or household member owes money on a resource. Equity value is the fair market value of the asset minus

- All money owed on the resource
- Any cost associated with the sale of the resource

Countable versus Exempt Resources

Resources of the applicant and eligible household members are to be considered in the eligibility evaluation process. Not all resources will be counted towards the maximum total allowable amount of $5,000.00.

Resource Types

Bank Accounts

Countable

- Checking
- Savings
- Certificates of Deposit
- Money Market accounts.
- Individual Retirement Account (IRA)
- Annuities
- Stocks
- Bonds.

Exempt

- 401(K) & 403(B)
- Keogh Plan
- Simplified Employee Pension (SEP)

Vehicles

Automobiles & Trucks

- Exempt the value of the applicant's primary vehicle.
- If the applicant or household owns more than one vehicle, apply the exemption to the vehicle with the highest equity value as the primary vehicle. Count the equity value of all other vehicles the applicant or household owns.

Other Vehicles

Count the equity or fair market value of other vehicles if not exempted as a primary vehicle or for business purposes. This includes motorcycles, boats, farm vehicles, motor homes, etc.

Property

Homestead

Exempt the applicant's homestead and surrounding property. This exemption also applies for the following conditions:

Any structure the household uses as a primary residence including trailer homes, motor homes, and houseboats. Note: If the household does not live in the structure it is counted as a resource.

Income Producing Property

Exempt property that the household owns, if it used to generate income. Examples of income producing property include;

- Machinery
- Business inventory
- Oil, gas, and mineral rights
- Livestock.

Verification of Resources

Verification is required for all counted resources. Resource values are assessed at the time of application.

Bank Accounts

- Current bank statement dated within 30 days from date of application or interview. Use the average daily balance as the countable resource amount.

Other Financial Accounts

- Most recent statement from the financial institution dated within 30 days or the last quarterly statement, whichever is more recent. Stocks and bonds may be calculated by applying the value of the particular stock or bond from a recent newspaper (value x number of shares).

Vehicles

- Vehicle values can be obtained from NADA's website http://www.nadaguides.com/ or related sources. The "Average Trade In" column is used. **Note:** Do not increase value if the vehicle has low-mileage. The applicant or household may provide an appraisal from a recognized car dealership if the vehicle is in less than average condition.

Property

- Use the tax appraisal district, financial institution, or statement from a real estate company.

Section IX. Application Process

Applicant Rights & Responsibilities

Residents of Cook County have the right to submit an application for review and eligibility determination. Each applicant should be treated with dignity and respect during an interview for potential program eligibility. Before completing the eligibility interview, Financial Counselors must:

- Ensure the applicant has a thoroughly completed application with all required supporting documentation.
- Review rights and responsibilities.
- Confirm the applicant understands the rights and responsibilities.
- Explain the program's eligibility and verification requirements.

Reasonable Judgment Rule

Unique applicant situations can and will arise. As such CCHHS will apply reasonable judgment in making eligibility determinations.

When staff encounter unusual applicant situations, or there is no clearly defined policy guideline. CCHHS encourages the use of logical judgment and sound reasoning in making eligibility determinations. The *"Reasonable Judgment Rule"* encourages staff to make reasonable decisions based on the best available information using:

- Program knowledge
- Experience
- Applicant circumstances

The rationale used to make the decision must be documented, including any references to applicable information sources.

Conflict of Interest

Financial Counselors must not process a charity-based program application if a conflict of interest exists. A conflict of interest is defined as situations where an employee/contracted employee and the applicant are in a personal relationship; situations in which the applicant is the employee's/contracted employee roommate, relative or acquaintance. Examples include:

- Father or mother
- Grandfather or grandmother
- Brother or sister

- Uncle or aunt
- First cousin
- Nephew or niece
- Stepfather or stepmother
- Stepbrother or stepsister
- First cousin once removed
- Neighbor
- Business Associate
- Acquaintance

The conflict of interest relationship restriction extends up to:

- The spouse of the listed relatives, even after the marriage has ended in death or divorce;
- The degree of "great-great" for uncles/aunts and nephews/nieces; and
- The degree of "great-great-great" for grandparents.

The conflict of interest also extends to include the spouse of the listed relatives even when the married couple (listed relative and spouse) is "separated." Financial Counselors should inform their immediate supervisor of the potential conflict of interest and request that another Financial Counselor determine the applicant's eligibility. Similarly, management staff must defer to another member of management if a potential conflict of interest exists during the appeals process.

Interview/Enrollment Appointments

CareLink enrollment will primarily be handled by appointment only. Patients requesting assistance will provided with detailed instructions and an application packet via telephone or in person. Once the applicants have completed the application and gathered all supporting documentation they will be provided with the phone number to call and schedule an appointment for a face-to-face interview with a financial counselor to determine eligibility. This process will primarily be initiated during the pre-registration process in the outpatient areas as well as while the patient is inpatient. Enrollment in the CareLink program will not be available to walk-in patients due to volume. Walk-in patients will be required to follow the same procedures and schedule an appointment once they've completed their application packet and have all supporting documentation available.

Application Submission

Applicants must complete the "Application for CareLink as part of the eligibility review process. The applicant or authorized representative can request an application in person or by telephone. All applications must be completed and signed by the applicant or a representative.

Note: CCHHS employees/contracted employees may assist with the completion of the application in situations where the applicant cannot reasonably complete the application him/herself, but the applicant or

representative must sign the application attesting to its accuracy. All applications for assistance through the CareLink program must be submitted complete and with all supporting documentation in order to be scheduled for a face-to-face interview appointment. Incomplete applications or applications missing the necessary supporting documentation will be denied. Denied applications and all supporting documentation will be returned to the applicant at time of denial and the patient will be provided with an "Eligibility Determination Notice" as well as instructions on how to re-apply for assistance.

Face-to-Face Interview

The interview process is a face-to-face interview with the applicant and by scheduled appointment only. Interviews will only be conducted if the application packet is 100% complete, and all supporting documents attached. Financial Counselors are the designated staff responsible for eligibility determination process.

Supporting Documentation

It is the responsibility of the applicant or representative to provide any and all supporting documents identified as necessary to determine eligibility during the interview. Failure to provide the appropriate documents will result in denial. The applicant will be responsible for re-scheduling another appointment once they have secured all required documentation.

Other Funding Program Sources

CareLink is a payer of last resort. Financial Counselors must explore potential eligibility for other funding program sources (e.g., Medicaid, Crime Victims, etc.) prior to certifying patients for eligibility. If a patient is potentially eligible for another financial assistance program(s) the patient must apply for assistance with the appropriate agency and denied prior to being approved for CareLink Assistance. Any patient who fails or refuses to comply with this eligibility requirement is not eligible for CareLink assistance. Accounts on patients who have applied for assistance through other funding sources will remain financially classified as "Self-Pay" until final disposition is reached on applications for assistance with the other funding sources. At CCHHS' management discretion applicants pending eligibility for Supplemental Security Income (SSI) assistance may be processed for CareLink assistance based on several factors. This might include consideration of the length of time it currently takes the Social Security Administration to process and approve claims for SSI, high account balances, and account aging. Another consideration would include the applicant's SSI claim and the current level of appeal with SSA.

Disposition of Application at Interview

The "Notice of Eligibility Determination" is the applicant's notice of eligibility status. At the end of the application review and face-to-face interview with the patient the financial counselor will have reached one of two outcome options. This includes:

- Approved Application

- Denied Application

Approved Application

The financial counselor will complete the "Notice of Eligibility Determination" letter informing the applicant of their eligibility (or continuing eligibility for recipients reapplying to extend their benefits). The "Notice of Eligibility Determination" letter will contain the following:

- Applicants name
- Medical record number
- Effective beginning and ending dates of CareLink eligibility (Eligibility Coverage Period)
- Level of Assistance (e.g., 100% or a partial discount)
- Effective date of the decision
- The right to appeal
- The right to re-apply

The financial counselor will advise the household about their right to appeal the decision if there are concerns about the amount of eligibility provided. Additionally, remind the recipient they are required to report any change in their residency, household composition, or income. Explain that failure to do so will result in termination of coverage dating back to the date of the unreported change.

Denied Application

The financial counselor will complete the "Notice of Eligibility Determination" letter informing the applicant of their denial. The "Notice of Eligibility Determination" letter will contain the following:

- Applicants name
- Medical record number
- Specific reason for denial; as listed below.
- Effective date of the decision
- The right to appeal
- The right to re-apply

i. Incomplete application or missing/invalid supporting documentation
ii. Residency outside Cook County, Illinois
iii. Failure to keep appointment
iv. Income exceeds program limits for applicant's household unit size
v. Access to employer-sponsored health insurance coverage
vi. Medicare Resource Limits Exceeded (Based on federal guidelines)
vii. Applicant's identification not established
8. Non-Compliance (Not completing the requirement to apply for other funding program sources)
9. Failure to report changes in "Residency, Household Composition, or Income."

Continuing Eligibility Reviews

Each time a recipient of the CareLink program presents for services at CCHHS registration staff must conduct a mini-review to establish continuing eligibility. This review is designed to determine if any changes have

occurred in the recipient's circumstances that would affect CareLink eligibility. Continuing Eligibility Reviews may also be conducted as part of the pre-registration for scheduled services. These changes include but are not limited to:

- Residency
- Income
- Employment
- Household composition
- Resources(Medicare Beneficiaries Only)
- Access to Employer group health coverage

Registration staff is required to conduct the continuing eligibility review questions in an open-ended question format, meaning the patient must provide responses with more than a YES or NO response. For example, instead of asking the patient, "Do you still reside at 1313 Mockingbird Lane?" the registrar would ask the question, "Can you please verify the address we currently have on file for you?"

When a status change is identified during the mini-review, the patient will be directed to a Financial Counselor who will interview the patient to determine if the status change affects program eligibility. This must occur prior to services being rendered, if possible. If not possible, this should be accomplished prior to the patient being discharged. Financial Counselors are responsible for explaining to the patient that failure to see a financial counselor could result in termination of their CareLink assistance. Additionally, the patient should be reminded that CareLink policy requires changes be reported within 14 days of the change. If the financial counselor determines the changes were not reported within 14 days of the change as required by policy, then CareLink eligibility should be terminated effective that day. In these situations, the patient must be provided with a "Notice of Eligibility Determination" stating reason for termination, as well as instructions for re-applying if the event the patient desires to re-apply.

Section X. Eligibility Periods

Automatic 12-Month Eligibility Period

Eligibility can remain in effect for a period of 12 consecutive months from the date of the approval. There are certain recipients who, when all eligibility criteria have been satisfied, may be eligible for a 12-consecutive month period. This includes:

- Medicare recipients
- Medicare/Medicaid recipients
- Recipients receiving disability and waiting for Medicare enrollment
- Pregnant women
- Children not otherwise eligible for Medicaid
- Applicants employed on the date of application approval
- Applicants exempted from employment services registration
- Applicants unemployed but registered for employment services

Retroactive Eligibility

Retroactive eligibility can be allowed for up to 12 consecutive months prior to the date of approval, provided the patient is met all eligibility criteria during that time frame. Retroactive eligibility applies only to the patient's self-pay account(s) or balances. Any patient who was not a verified Cook County resident or did not meet all of the eligibility criteria in any of the 12 months prior to the date of application approval is not eligible for retroactive coverage for that month(s).

Eligibility Extension – Hospitalization

In certain situations, an eligible patient will be hospitalized beyond the "Effective To" date on the CareLink program; although, at admission, the eligibility was in effect. When this occurs, the patient's eligibility is adjusted to discharge date.

Less than 12-Month Eligibility Period

The enrollment period for CareLink is not 12 consecutive months in the following situation:

- Recipients who claim temporary incapacity and do not register for employment services.

The applicant will need to provide proof of temporary incapacity by having a treating physician or licensed clinician (such as a physician assistant or registered nurse) complete a "Medical Statement." The length of eligibility is based on the amount of time the physician or clinician certifies the patient as being temporarily disabled. An example is provided below.

A male, 27 year-old patient with a fractured leg does not have a long-term disability. He states he works in construction and won't be able to work for a while. The patient applies for CareLink assistance on September 2nd. The patient has his doctor complete the Medical Statement, which indicates that the patient cannot return to work for three (3) months. The patient brought in all other documentation and otherwise meets criteria.

The patient would be certified effective from September 2nd and lasting to December 2nd. At the end of this eligibility period the patient would need to re-establish eligibility by registering for employment services with IDES, or obtaining a second medical statement certifying the extension of the patient's temporary incapacity.

Eligibility Periods Based on Medical Statement

Every applicant needing a medical statement must have the statement completed by a licensed physician, physician's assistant, or nurse practitioner familiar with the patients care. The statement must include language related to one of the three following designations.

- ***Permanently Incapacitated***

  This designation is used for patients with a medical condition or illness that prevents a return to work permanently. Applicant is eligible for a period of up to 12 consecutive months.

- ***Indefinitely Incapacitated***

  This designation is used for patients where the medical condition is severe, a return to work is not immediately known, but the condition may not be permanently disabling. Applicant is eligible for a period of up to six (6) consecutive months. A re-evaluation of the medical condition must occur after the eligibility period ends.

- ***Temporarily Incapacitated***

  This designation is used for patients treated for a medical condition that, under usual medical circumstances, can be expected to last for a finite period of time; for example, recovery from an appendectomy. The clinician must state a definitive period of time the patient's temporary incapacity can be expected to last. Applicant is eligible for the period of time as described in the medical statement. A re-evaluation of the medical condition must occur after the eligibility period ends if the patient wants to continue eligibility based on the temporary incapacity.

Note: Enroll an eligible applicant for a minimum of one (1) month if the medical statement indicates a treatment period of less than 30 days.

Dual Medicare & Medicaid Eligibility

Applicants eligible for Medicare and Medicaid simultaneously are deemed "Indigent" by Federal and State Government Agencies and therefore qualify for CareLink. Medicare eligible patients also eligible for any of the following Medicaid programs should be considered financially eligible for the CareLink program:

- Any Traditional or Managed Care Medicaid Plan
- Medicaid Qualified Medicare Beneficiary (MQMB)
- Qualified Medicare Beneficiary (QMB)

Dual eligible applicants must provide the following documentation:

- Proof of Medicare and Medicaid eligibility at the time of application, and
- Cook County residency.

*****All other eligibility elements are waived for Dual Eligible applicants*****

Eligibility secondary to commercial or managed care

Applicants with a commercial health insurance or managed care health insurance plan may be eligible for CareLink assistance as a secondary plan. The applicant's health insurance plan must be considered "in-network" (contracted with CCHHS or a "fee-for-service" indemnity policy) as a part of the eligibility assessment. The applicant must also meet all other applicable eligibility criteria as described in this policy.

Section XI. Complaints, Grievances, and Appeals

Overview

- Applicant disagreements regarding denials should be addressed to the financial counselor completing the denial.
- If the applicant is not satisfied with the explanation or reason, the applicant may file an appeal by contacting the financial counseling supervisor where the interview took place. The financial counselor or supervisor upon receipt of notice of appeal, either written or verbal must schedule an appointment with the applicant to hear their appeal within 10 business days. The applicant may be required to present additional documentation in compliance with this policy for the appeal process.
- The financial counseling supervisor will review the patients CareLink application and all supporting documentation and determine if the appeal hearing is necessary in order to reach a favorable decision. If the hearing is necessary, it should take place as scheduled. If not, the hearing is cancelled and the patient notified of the favorable outcome. The patient must be notified of the financial counseling supervisor's decision no later than 10 business days following the appeal hearing.
- If the applicant is not satisfied with the Financial Counseling Supervisor's decision, the applicant will be referred to the Financial Counseling Director for further review. The Financial Counseling Director will review the file and render a final decision in writing and notify the applicant within 10 business days from the date the appeal was referred. The Financial Counseling Director may request that the patient provide additional documentation to assist in resolving the dispute.
- If the applicant is not satisfied with the Financial Counseling Director's decision, the applicants file will be referred to the Director of Financial Control for final resolution.

APPENDIX:

A. Application for CareLink assistance

B. Federal Poverty Income Level Chart

C. Notice of Eligibility Determination

D. Supporting Documentation List

E. Open Letter to Community

F. Staff Physician's Medical Statement

G. Declaration of Residency

Cook County Health & Hospitals System

Patient Access

Policy Title: Accident Data Collection Policy & Procedure		**Policy Number**:RCPAS01
Date of Original Policy: 1/1/2009 **Revised:** N/A	☐ Core Policy ☑ Area Specific Policy	**Pages:** 3

Purpose:

Patients who seek care in an emergency department setting or who are scheduled for services that are related to an injury, may be covered under a payer source other than their primary health insurance.

The purpose of the following policy and procedure is to establish a standard process for the collection of data related to workers compensation, crime victims, auto and other accident related visits that are scheduled or treated in an emergency setting.

Scope:

This policy and procedure will pertain to all Cook County Health and Hospital's System entities and CCHHS Affiliates.

Policy:

The Accident Data Collection-Registration Policy is defined as the required actions to secure accident information from patients seeking services as a result of injury. Injuries may be the result of auto accidents, work related accidents, crime related incidents, and other liability situations.

All registration points are required to obtain detailed accident information including; location, date and time, how injury occurred and payer source (liability injuries). In emergent cases, treatment will occur prior to validating payer source but verification of payer source will be completed prior to final bill.

Approved By:	Date:

Procedures:

Pre-Registration

A. Patient Access Specialist identifies scheduled service(s) relating to an accident through a report pulled from Cerner

B. Patient Access Specialist contacts patient by phone to obtain accident details and liability information:
    a. Patient Access Specialist collects location of accident
    b. Patient Access Specialist collects date and time of accident
    c. Patient Access Specialist collects payer source
        1. Worker's Compensation
        2. Auto Insurance
        3. Victim Compensation Program (VCP)
    d. Patient Access Specialist collects contact names, phone numbers and claim numbers required to validate coverage for scheduled service

C. Patient Access Specialist verifies coverage for services related to auto, worker's compensation and tort liability accidents (see insurance verification-scheduled services policy)
    a. Documents coverage details in Cerner notes
    b. Flags account in Cerner with appropriate accident category (auto, worker comp, tort)
    c. Changes insurance sequence making health insurance the secondary payer

D. Patient Access Specialist verifies coverage for the Victims Compensation Program by calling 800-228-3368
    a. Documents coverage details in Cerner notes
    b. Flags account in Cerner as crime victim
    c. The Victims Compensation Program is the payer of last resort and is placed as the secondary payer if patient has health insurance

E. Patient Access Specialist obtains required authorization, referrals and pre-certification to perform scheduled service (see pre-registration authorization/pre-registration reschedule policies)

F. Patient Access Specialist documents verification information clearly in Cerner notes

A. Emergency Department (ED) Registrar will ask each emergency room patient whether the service is related to an injury

B. ED Registrar identifies accident category (worker's compensation, auto or crime victim) and requests accident details from patient

C. ED Registrar completes first report of injury if accident is new including:
    a. Contacting employer to obtain worker's compensation claim information and report injury
    b. Contacting auto insurance to report accident
    c. Contacting Victim Compensation Program after police report is complete and after receipt of clear documented consent from patient
    d. Contacting other third party liability to report or validate accident information

D. ED Registrar documents accident details including location, date/time, payer source and liability contact information in Cerner notes

E. ED Registrar flags account in Cerner with appropriate accident category

F. ED Registrar or designee performs next day follow up on liability accounts until all claim information is received, validated and entered into Cerner

G. For Medicare Patient's, the Medicare Secondary Payer Questionnaire will be completed appropriately to reflect the correct Coordination of Benefits. For Accident related services, Medicare will not be listed as primary.

Cook County Health & Hospitals System

Patient Access

Policy Title: Bed Management Policy & Procedure		**Policy Number**:RCPAS02
Date of Original Policy: 1/1/2009 **Revised:** N/A	☐ Core Policy ☑ Area Specific Policy	**Pages:** 3

Purpose:

The Hospital admits patients suffering for all types of disease and varying physical conditions. Referrals/orders for inpatient or outpatient services must be made by the patient's physician.

Approved By:	Date:

Procedures:

1. The Patient Access Department is notified of all Inpatient admission requests by the patient's physician or the outpatient service department (i.e. emergency room, Radiation Oncology, Same Day Surgery etc.).This notification may be provided several weeks prior to the actual admission, but may occur up to and including the day of admission. Reservations are received in bed control 24 hours a day, 7 days a week.

2. For admissions, demand for hospital beds frequently exceeds the supply; therefore, patients are classified on the basis of medical need. The classification of the patients' medical status is the full responsibility of the patient's physician. Patients suffering from the severest illness or injury have the highest priority admission and are admitted to the first available bed.

3. Three basic types of admissions are seen at the hospital (Emergency, Urgent, and Elective).

4. The bed controller will coordinate bed assignments in a timely manner with nursing supervisors, rapid admission nurses, charge nurses, and nurse management if necessary. A patient may be assigned a bed in another clinical area until one is available in the unit for which their condition is appropriate. Bed assignments will be performed in a fair and equitable manner, in accordance with the medical needs of the patient population.

5. When the hospital is experiencing a low occupancy rate, patients can be admitted as orders are received and considering the urgency of the admission.

6. The assigned bed controller will attend the daily bed utilization meeting to determine potential discharges, transfers and admissions for the day. In addition they will reconcile that information to the electronic bed board and pending discharge lists.

7. Bed Control personnel will receive admission order requisitions via Observation-ER-Admit work lists available for monitoring on the Cerner Patient Management Tool.

8. Direct Admissions will be called in directly to the Bed Control Unit from the Physicians Office. A Rapid Admissions Nurse, Utilization Management designee, or Physician liaison will review the request for Direct Admission and all related clinical conditions to validate the medical appropriateness of an inpatient order.

9. Bed Control personnel will change the encounter type to the appropriate Inpatient or Observation type when the order is received. ED admissions orders and patient floor admission electronic orders will prompt a bed reservation to print in the Bed Control area. In addition, a bed request will display on Bed Control's Cerner PM work list.

10. Bed Control Personnel will monitor the beds waiting to be cleaned via the Bed Tracking Board.

11. Once the bed has been cleaned Bed Control will enter the room assignment in the PM work queue. The Environmental Services staff will be responsible for timely preparation of unoccupied rooms for placement of the next patient.
    A. The Admitting Registrar will then admit the patient to the assigned bed.

12. When there is no bed available at the time the Admission Order Requisition is placed by the ED physician, Bed Control will assign the patient to an ED hold bed (virtual bed).
    A. The Admitting Registrar will admit the patient to the ED hold bed.

13. Once a bed becomes available on the appropriate patient floor, Bed Control will enter the bed assignment in the comments field on the ED Bed Assignment conversation. The Bed Control Personnel will call for an active status on pending discharge beds every hour.
    A. ED clerk will transfer the patient from the ED hold bed to the new location using the Zbed Transfer conversation on Cerner FirstNet.

14. A Bed Controller will walk the patient floors each shift and reconcile bed assignments to the bed census available on Cerner.

15. All admissions will simultaneously display on Case Managements Cerner work list as well to initiate concurrent review of all stays.

16. All admissions will be reviewed by an insurance verifier for appropriate insurance classification and determination of coverage benefits.

17. Uninsured and under-insured patients will be screened by a Financial Counselor for medical assistance enrollment of other adequate financial arrangements.

Cook County Health & Hospitals System **Services**		**Patient Access**
Policy Title: Emergency Department Point of Service Collection Policy & Procedure		**Policy Number**:RCPAS03
Date of Original Policy: 1/1/2009 **Revised:** N/A	☐ Core Policy ☑ Area Specific Policy	**Pages:** 2

Purpose:

Point of Service collections are beneficial for both the patient and organization as it gives the patient the opportunity to pay the outstanding liability up front and reduces overall collection costs and provides patient debt resolution.

The purpose of the following Emergency Department Point of Service Collections Policy is to outline the procedure for verifying patient benefits, calculating patient deposit amounts and collecting patient payments at time of discharge.

Scope:

This policy and procedure will pertain to all Cook County Health and Hospital's System Emergency Departments.

Policy:

The Emergency Department Point of Service Collections Policy is defined as the actions taken to obtain insurance benefit information, calculate estimated patient liability (including prompt pay discounts for uninsured), identify outstanding patient balances and collect deposit amounts at time of discharge from the Emergency Room.

For emergent services, insurance eligibility and benefits verification must be performed at the time of service, after any necessary stabilizing treatment has begun.

Approved By:	Date:

Procedures:

1. Emergency Department (ED) Registrar completes patient registration and makes copies of insurance cards

2. ED Registrar uses on-line verification tools to verify insurance eligibility and obtain emergency department benefits.
    a. If coverage is terminated, ED Registrar asks patient if other insurance is available (after medical screening evaluation and stabilization is complete)
    b. If no other insurance is available, account is referred to the ED Financial Counselor.

3. ED Registrar documents emergency room co-pay, remaining deductible and co-insurance in Cerner notes.

4. The ED Registrar will utilize the established fee schedule or other automated tool to determine deposit amount required upon patient's discharge and documents deposit amount in Cerner notes. (Fee Schedule under review).

5. ED Registrar refers self pay accounts to ED Financial Counselor:
    a. Registrar provides face sheet
    b. Registrar provides copy of photo id
    c. Registrar provides verification results that indicate no active Medicaid or other insurance coverage

6. ED Financial Counselor calculates estimated/preliminary emergency room charges:
    a. ED Financial Counselor discusses/identifies evaluation and management level with attending nurse
    b. ED Financial Counselor discusses/identifies all diagnostic services performed or ordered with attending nurse
    c. ED Financial Counselor discusses/identifies all pharmaceuticals administered or ordered with attending nurse

7. ED Financial Counselor uses automated tool to calculate patient's estimated self pay liability and prompt pay/patient discounts

8. ED Financial Counselor will determines if patient meets financial assistance requirements during the patient interview and assists with enrollment into the most appropriate medical assistance program available (See Financial Counseling Policy for programs and eligibility criteria).

9. Patients subsequently admitted as inpatients from the ED or placed in an observation status will follow the same process. Patients will be screened in the same manner in order to finalize adequate financial arrangements prior to discharge.

Cook County Health & Hospitals System **Services**		**Patient Access**
Policy Title: General Registration Policy & Procedure		**Policy Number**:RCPAS04
Date of Original Policy: 1/1/2009 **Revised:** N/A	☐ Core Policy ☑ Area Specific Policy	**Pages:** 3

Purpose:

Referrals for inpatient or outpatient services must be registered accurately in order to secure payment for services rendered and improve the patient experience. Registration Associates are expected to act in a professional and courteous manner throughout the patient interview process and are required to obtain accurate patient demographic and financial information.

Approved By:	Date:

Procedures:

1. The Patient Access Department will complete registrations for inpatient and outpatient services provided by the Cook County Health and Hospital's System. Registrations will be completed accurately and efficiently and within the guidelines governing elective, urgent, and emergent access areas.

2. Outpatient services for patients must be accompanied by a referral/script and must include a valid diagnosis and required physician information. If a physician has either verbally requested a "STAT" procedure or provided a written "STAT" referral/script, the patient will be quickly registered and allowed to have the requested services rendered regardless of the financial clearance requirements. The Registration Associate will be responsible for making a good faith effort to obtain all insurance requirements without delaying the STAT services (i.e. pre-certifications, authorizations, referrals, etc.). STAT requests will be honored regardless of the patients ability to make financial arrangements (i.e. provide insurance info, make payment, or provide the appropriate documentation for enrollment in other hospital assistance programs).

3. Patient Access staff will perform pre-registration of the patient for scheduled services when ample time exists between the arrangement of the admission and arrival. Pre-registration may be completed by direct (in-person) interview of the patient or telephonically.

4. The Patient Access employee receiving the request will obtain all required information during the reservation/pre-registration call. The following information is essential to the reservation process and will be recorded in the Patient Management System.
   4.1. Admitting/Referring physicians name
   4.2. Patient Full Name
   4.3. Age and Date of Birth of Patient and Insurance subscriber
   4.4. Patients Sex
   4.5. Room/outpatient service requirements
   4.6. Date of service/admission
   4.7. Admission/referring diagnosis
   4.8. Complete demographic information/Insurance information

5. All demographic and financial information will be entered into the Patient Management system completely and accurately.

6. Photocopies of the patients Identification and Insurance cards will be made for the patient financial record.

7. All patients will be questioned concerning their participation in the Advanced Directive (Living Will) process.

8. All patient consents and payment agreements will be signed and a copy will be filed for Cook County Health and Hospital System record in accordance with file retention regulatory standards.

9. All face sheets and patient documentation will be verified and an armband must be secured to the patients' wrist where applicable

10. Patient Access representatives are responsible for verifying all insurance information. Registration Associates may use electronic means as well as telephone to obtain all insurance requirements. Please refer to line item 2 for details on handling "STAT" procedures.

11. The on-line eligibility system must be used to verify coverage for those payers that participate.

12. Patients without financial means of making payment or who are uninsured or under insured will be referred to the Financial Counseling Department to be screened for eligibility of financial assistance programs. For all elective services, patients must make adequate financial arrangements prior to receiving services. Adequate financial arrangements include enrollment into a Medical Assistance program defined in the Financial Counseling Policy or payment arrangements made within CCHHS guidelines.

13. Patients will be required to sign a payment agreement accepting responsibility in the event their insurance coverage does not make payment and/or assigns a portion of the bill towards the patient's responsibility.

14. Medicare patients will be given the Important Message from Medicare and asked to sign as required. Another copy of the signed Important Message from Medicare will be given to the patient by a case manager no earlier than two days prior to discharge.

15. Where applicable, outpatient Medicare services will be validated against an Advance Beneficiary Notice tool to determine medical necessity. Elective Medicare patients with services that do not meet medical necessity criteria will be required to sign an ABN form prior to services rendered.

16. For Emergency Room patients, an electronic sign-in will be initiated to record the arrival time. This electronic sign-in process will capture the patients name, date of birth, social security number (if available), and chief complaint. A complete registration, including all pertinent demographic and billing information, will not be completed until the Registration Associate has verified that the triage assessment was completed and the patient is in a stabilized condition.

17. For all Access Points, patients that speak a language other than English will be handled in accordance with the Hospitals Language Interpretation Policy.

18. Patient Registrations will be audited for accuracy and errors will be communicated to the employee for re-education. Registrars will be required to maintain a 98% accuracy rate for scheduled services and a 96% accuracy rate for unscheduled registrations (Refer to the Quality Assurance Policy for details).

Cook County Health & Hospitals System		**Patient Access**
Policy Title: Insurance Verification/Authorization Policy Policy & Procedure		**Policy Number**:RCPAS05
Date of Original Policy: 1/1/2009 **Revised:** N/A	☐ Core Policy ☑ Area Specific Policy	**Pages:** 4

Purpose:

Each hospital verifies insurance benefits, obtains authorizations/referrals, pre-registers and counsels patients prior to a scheduled date of service. Financial clearance is required before a patient's service in order to preserve financial viability and to create a satisfactory patient experience.

The purpose of the following policy and procedure is to establish an efficient process for managing patient expectations regarding payer authorization requirements and financial responsibility. This policy outlines the actions required to effectively evaluate and approve elective services that fail to meet financial clearance criteria.

Scope:

This policy and procedure will pertain to all Cook County Health and Hospital's System entities and CCHHS Affiliates.

Policy:

The Authorization Policy process is defined as the necessary actions taken to notify a patient of potential delays or denials in service prior to the service date. In addition, if rescheduling services is necessary, this policy provides leadership approval steps and alternatives to rescheduling.

Approved By:	Date:

Procedures:

1. Patient Access Specialist and Financial Counselor perform all actions required to financially clear scheduled services:
   a. Insurance verification of eligibility and benefits
   b. Validate appropriate authorization or referral for service
   c. Validate accurate and complete patient demographics
   d. Review physician's order for completion and medical necessity (outpatient services)
   e. Patient's ability to pay liability (deposit, discounted amount, prior debt)
   f. Pre-screen and vendor review to qualify for financial assistance

Ambulatory non-urgent/non-emergent services

2. If authorization or referral is required but not on file with payer at time of scheduling, the service will be scheduled using the "pending status" routine in the Cerner Scheduling:
   a. Pre-registrar/Insurance Verifier notifies patient at time of scheduling that he/she may be financially liable for the services, if authorization is not secured prior to service
   b. Pre-registrar/Insurance Verifier contacts ordering physician's office to discuss authorization delay and rescheduling opportunities if authorization is not obtained (see pre-registration obtaining authorization policy)
   c. Pre-registrar/Insurance Verifier notifies Department Supervisor if authorization is not secured and validated by 2 p.m. the day before scheduled service
   d. Decision is made by PFS Leadership, Care Manager and ordering physician to reschedule patient or proceed with service if patient wishes to pay for services out of pocket

Surgical non-urgent/non-emergent services

3. If authorization or referral is required but not on file with payer by 2 p.m. the day before the procedure:
   a. Pre-registrar/Insurance Verifier notifies Department Supervisor of authorization delay
   b. Department Supervisor contact clinic physician's staff to discuss authorization delay and rescheduling opportunities
   c. Patient Access Supervisor contacts patient to inform them of authorization delay and possible rescheduling
   d. Once determination is made Department supervisor will notify Pre-registrar/Insurance Verifier of the delay or rescheduling.
   e. Insurance Verifier works with physician's office to exhaust every effort to obtain authorization prior to service
   f. Care Management, based on medical necessity, makes decision to reschedule the procedure and notifies physician's office
   g. Patient Access Supervisor contacts patient to notify them of unauthorized procedure and discusses rescheduling opportunities

h. Patients with confirmed patient responsibility for deductible related costs exceeding $500.00 for outpatient services or $1000.00 for inpatient will be expected to make an acceptable deposit at time of service and set up payments for balance.
i. Patients will be rescheduled if provided the opportunity to set up acceptable arrangements and or financial assistance and the patient refuses to comply

j. If a patient does not meet all other financial clearance by 2 p.m., Pre-registrar/Insurance Verifier notifies Patient Access Leadership and supplies account details. The patient should have already received several calls throughout attempts to verify data and complete a pre-registration that would also inform them that services would be postponed if all requirements were not met.

k. Patient Access Leadership solicits assistance from Subject Matter Experts in order to make last attempt to complete necessary financial clearance steps

l. If financial clearance is unsuccessful:

m. Patient Access Leadership notifies PFS Leadership and Patient Care Leadership of rescheduling opportunities and provides the following:
    1. Patient name
    2. Date of service
    3. Ordering physician
    4. Type of service
    5. Estimated charges
    6. Estimated cost to perform service
    7. Date of service
    8. All documentation and notes (specific to communication with patient)

n. PFS Leadership and or the Patient Care Leadership contacts the ordering physician's office to discuss incomplete financial clearance and rescheduling opportunities
    1. Will rescheduling service affect patient outcome
    2. Can service be performed at a lower level setting
    3. Can a less invasive procedure/service be performed

o. PFS Leadership contacts patient to discuss incomplete financial clearance and rescheduling opportunities

p. Decision is made by Patient Access leadership, PFS leadership, and Patient Care leadership to reschedule patient or proceed with service. Emergent or Urgent cases will not be postponed or delayed regardless of a missing authorization.

q. Pre-registration/Insurance Verifier documents detailed information in Cerner notes including communication with patient, physician, Patient Access Leadership, PFS Leadership, and Patient Care Leadership.

Emergent/Urgent Services

4. Emergent and/or Urgent services are exempt from the requirement to verify patient financial/insurance information prior to services being performed/provided. Emergent services are defined as those services, which if not performed on a patient in a serious condition, could result in physical harm or impairment of critical organ functions in a patient that may or may not have long-term or fatal results on the patient's health and bodily functions. Please refer to the Financial Clearance Policy for appropriate handling of these accounts.

Cook County Health & Hospitals System

Patient Access

Policy Title: Pre-Registration Add-on Policy & Procedure		**Policy Number**:RCPAS06
Date of Original Policy: 1/1/2009 **Revised:** N/A	☐ Core Policy ☑ Area Specific Policy	**Pages:** 3

Purpose:

Patient care is priority at CCHHS. On occasion a service is scheduled less than two days from booking date due to critical patient needs. Add-on services require the same attention and focus as services scheduled greater than two days from booking date.

The purpose of the following policy and procedure is to establish an efficient process for verifying insurance eligibility and benefits, obtaining authorization and pre-registering a patient's account prior to patient's arrival.

Scope:

This policy and procedure will pertain to all Cook County Health and Hospital's System entities.

Policy:

The Add-on Services Pre-Registration Process is defined as the necessary actions taken within a narrow timeframe to prepare a patient's account. The goal is to expedite a patient's registration process by performing insurance verification, obtaining authorization and validating patient demographics before the patient arrives for services. Add-on patient accounts take priority over patient accounts scheduled greater than two days from the expected service date.

Approved By:	Date:

Procedures:

A. SDS Clinic or OR Scheduling informs Patient Access Specialist/Pre-Registrar of an add-on service (service date less than 2 days from booking date). Procedures will not be permitted to be scheduled within 48 hours of the expected service date unless they are of an emergent/urgent medical nature.
    1. Scheduling places a phone call to Patient Access Specialist/Pre-Registrar providing notification
    2. Scheduling sends a booking slip either through printer or fax to Patient Access Specialist/Pre-Registrar that contains:

        1. Patient Name
        2. Date of Birth
        3. Social Security Number
        4. Account Number
        5. Type of Service (include CPT codes if possible)
        6. Patient Type (INPT, OP, SDS, RCR)
        7. Diagnosis (include ICD-9 codes if possible)
        8. Physician Name and Phone Number
        9. Patient Phone Number
        10. Primary and Secondary Insurance Plan Code

B. Time permitted, Patient Access Specialist/Pre-Registrar contacts the patient via phone call, verifies demographics including Medicare Secondary Payer Questionnaire (if applicable), and provides benefit information including potential liability.

C. Patient Access Specialist/Pre-Registrar verifies the patient's insurance eligibility, benefits and determines if authorization/referral is required.

D. If authorization or referral is required for the scheduled service, Patient Access Specialist/Pre-Registrar contacts primary care physician (PCP) or ordering physician to obtain authorization/referral.
    1. If authorization is not obtained before the patient's arrival, Patient Access Specialist/Pre-Registrar escalates account to Patient Access Supervisor for resolution
    2. Patient Access Supervisor works with physician's office and insurance company to determine the likelihood of service being authorized
    3. If the patient is uninsured, Financial Counseling will be required to contact the patient and physicians office to ensure that the patient can be screened for adequate financial arrangements, including enrollment into several Medical Assistance options.
    4. For elective services, payment upfront will be required if no other financial arrangements have been made. Requested payment will be determined by the established patient payment fee schedule/liability guidelines.
    5. A decision is made by Financial Counseling and Patient Care leadership to perform service without obtaining authorization prior to rendering services.

E. The patient account is pre-registered in Cerner and pre-registered packet is created including:
    1. Face sheet
    2. Condition of Admission (COA)
    3. Advanced Beneficiary Notice (ABN) if applicable
    4. Important Message from Medicare (IM) if applicable
    5. Arm bands and labels
    6. Booking sheet

F. The Patient Access Specialist/Pre-Registrar delivers a completed pre-registered packet to the appropriate registration area.

Cook County Health & Hospitals System

Patient Access

Policy Title: Identity Theft Prevention Program Policy & Procedure		**Policy Number**:RCPAS07
Date of Original Policy: 3/18/2009 **Revised:** N/A	☑ Core Policy ☐ Area Specific Policy	**Pages:** 8

Purpose:

Under the Red Flag Rule, every "Creditor" with "Covered Accounts" is required to establish an Identity Theft Prevention Program tailored to the size, complexity and nature of its operations. The Program must contain policies and procedures reasonably designed to:

1. Identify relevant "Red Flags" for new and existing "covered accounts" and incorporate those Red Flags into the Program.
2. Be able to detect Red Flags that have been incorporated into the Program.
3. Respond appropriately to any Red Flags that are detected in order to prevent and mitigate "Identity Theft."
4. Update the Program periodically to reflect changes in risks to our patients and to the safety and soundness of our Organization from Identity Theft.

Scope: Adoption of The Identity Theft Prevention Program

Cook County Health and Hospitals System developed this Identity Theft Prevention Program ("the Program") pursuant to the Federal Trade Commission's Red Flag Rule ("the Rule"), 16 C.F.R. §681.2. The Program was developed with the oversight and approval of the Organization's [Board of Directors/Managing Partner/Managing Member] who has determined that our Organization is a Creditor with Covered Accounts (as defined below) and is obligated to comply with the Rule. After due consideration of the Rule's requirements and its guidelines, and of the size and complexity of the Organization's operations and systems, and the nature and scope of the Organization's activities, the [Board/Managing Partner/Managing Member] determined that this Program is reasonable and appropriate for the Organization.

Policy:

The Identity Theft Prevention Program Policy provides guidelines to follow to prevent or eliminate the risk for Identity Theft of Cook County Health and Hospitals System patients. The policy also provides instructions for addressing incidents of Identity Theft or potential Identity Theft events.

Approved By:	Date:

Definitions:

A. Definitions of Terms used in the Program

1. Identity Theft is fraud committed using the identifying information of another person, which can be medical identity theft and/or financial identity theft.

2. A Creditor is any person or entity who:

   i. regularly extends, renews or continues credit;
   ii. regularly arranges for the extension, renewal or continuation of credit; or
   iii. any assignee of an original creditor who participates in the decision to extend, renew or continue credit.

3. A Covered Account is:

   i. an account that a creditor offers or maintains, primarily for personal, family or household purposes, that involves or is designed to permit multiple payments or transactions; and
   ii. any other account that the creditor offers or maintains for which there is a reasonably foreseeable risk to patients or to the safety and soundness of the creditor from Identity Theft.

4. Because our Organization regularly extends credit to patients by establishing an account that permits multiple payments, our Organization is a Creditor offering Covered Accounts. Commentary to the Rule states that “creditors in the health care field may be at risk of medical identity theft (i.e., identity theft for the purpose of obtaining medical services) and, therefore, must identify Red Flags that reflect this risk.”

5. Identifying Information is defined under the Rule as any name or number that may be used, alone or in conjunction with any other information, to identify a specific person, including name, address, telephone number, social security number, date of birth, government-issued driver’s license or identification number, alien registration number, government passport number, employer or taxpayer identification number, unique electronic identification number, computer’s Internal Protocol Address, or routing code.

6. Red Flags are patterns, practices or specific activities that indicate the possible existence of Identity Theft in connection with a Covered Account.

7. Program Administrator is the Organization's administrative personnel charged with the implementation of the Program (which may be one or more persons and may be the Organization's HIPAA Privacy Officer).

Policies and Procedures:

A. Identification of Red Flags

In order to identify relevant Red Flags, our Organization considers the types of accounts it offers and maintains, the methods it provides to open its accounts, the methods it uses or provides to access its accounts, and its previous experience with Identity Theft.
The Organization has identified the following Red Flags for our Program:

1. Alerts, Notifications and Warnings Received from Consumer Reporting Agencies or Service Providers of the Organization

    a. Report of fraud or active duty alert accompanying a credit or consumer report.

    b. Notice of a credit freeze in response to a request for a consumer report

    c. A notice of address discrepancy

    d. Report that indicates a pattern of activity that is inconsistent with the history and usual pattern of activity of a patient account

2. Suspicious Documents

    a. Identification document that appears to be forged, altered or otherwise not authentic

    b. Identification document on which a person's photograph or physical description is not consistent with the person presenting the document

    c. A patient who has an insurance number but never produces an insurance card or other physical documentation of insurance (unless the Organization can confirm that there is a legitimate reason for the absence of such documentation)
    d. Other document with information that is not consistent with existing

patient information (such as if a person's signature appears forged, based on previous instances of the person's signature in the file)

3. Suspicious Personal Identifying Information

a. Identifying information presented that is inconsistent with other information the patient provides (e.g., inconsistent birth dates)

b. Identifying information presented that is inconsistent with other sources of information (e.g., an identification number presented that does not match a number on the person's insurance card)

c. Identifying information presented that is the same as information shown on other documents that were found to be fraudulent

d. Identifying information presented that is consistent with fraudulent activity (e.g., invalid phone number or fictitious billing address)

e. Identifying information presented that is the same as information provided as identifying information by another patient

f. A patient fails to provide complete identifying information on any patient information form when reminded to do so and the Organization is not prohibited by law from requiring the information be provided

g. A patient presents identifying information that is not consistent with the information the Organization has on file for the patient

4. Suspicious Account or Medical Record Activity

a. Payments stop on an otherwise consistently up-to-date account

b. Mail sent to the patient is repeatedly returned as undeliverable

c. Breach in the Organization's computer system security

d. Unauthorized access to or use of Covered Account information

e. Records showing medical treatment that is inconsistent with a physical examination or with a medical history as reported by the patient, e.g., discrepancies in age, race, blood type or other physical descriptors

5. Alerts from Others

a. A complaint or question from a patient based on the patient's receipt of:

i. A bill for another individual
ii. A bill for a product or service that the patient denies receiving
iii. A bill from a health care provider that the patient never patronized
iv. A notice of insurance benefits or Explanation of Benefits for health services never received

b. A complaint or question from a patient about the receipt of a collection notice from a bill collector

c. A complaint or question from a patient about information added to a credit report by the Organization or the patient's insurer

d. A dispute of a bill by a patient who claims to be the victim of any type of identity theft

e. A patient or insurance company report that coverage for legitimate medical services is denied because insurance benefits have been depleted or a lifetime cap has been reached

f. A notice or inquiry from an insurance fraud investigator regarding a patient's account (which could indicate internal or external Identity Theft)

g. A notice or inquiry from a law enforcement agency regarding possible Identity Theft in connection with a covered account held by the Organization

h. A notice from a victim of Identity Theft regarding possible Identity Theft in connection with a covered account held by the Organization.

B. Detecting Red Flags

1. New Accounts – In order to detect any of the Red Flags identified above associated with the opening of a new Covered Account, the Organization's personnel will take the following steps to obtain and verify the identity of the person opening the account:

a. Require certain identifying information such as: name, date of birth, residential or business address, insurance card, employer name and address, driver's license or other identifying information.

b. Actually verify the patient's identity by reviewing the identifying information presented and contacting the patient's insurer, if appropriate.

2. Existing Accounts – In order to detect any of the Red Flags identified above for an existing account, the Organization's personnel will take the following steps to monitor the transactions and activity on an account:

a. Verify the identification of a patient who requests information (in person, via telephone, via facsimile, via email), consistent with the the Organization's HIPAA Privacy Program.

b. Verify the validity of requests to change a billing address

c. Verify changes in credit card or other information given for purposes of billing and payment

C. Preventing and Mitigating Identity Theft

In the event the Organization's personnel detects any identified Red Flags, the Organization shall take one or more of the following steps, depending on the degree of risk posed by the Red Flag:

1. Prevent and Mitigate

a. Continue to monitor an account for evidence of Identity Theft

b. Contact the patient (unless state law requires that law enforcement be contacted prior to disclosure to the patient)

c. Change any passwords or other security devices that permit access to a Covered Account

d. Not open an account for a new patient if a Red Flag is detected in relation to such account

e. Place a hold on further transactions related to an account for which a Red Flag has been detected

f. Not attempt to collect on an account

g. Notify the Program Administrator or the Organization's legal counsel for determination of the appropriate step(s) to take

h. Notify law enforcement in accordance with the New Jersey Identity Theft Act and regulations

i. Determine that no response is warranted under the circumstances

2. Protect Patients' Identifying Information

The Organization's HIPAA Privacy and Security Program will be utilized to further prevent the likelihood of Identity Theft occurring with respect to the Organizations accounts.

D. Program Updates

The Program Administrator will periodically review and update this Program to reflect changes in risks to patients and the soundness of the Organization in protecting against Identity Theft, taking into consideration the Organization's experience with Identity Theft occurrences, changes in methods of how Identity Theft is being perpetrated, changes in methods of detecting, preventing and mitigating Identity Theft, changes in the types of accounts the Organization offers, and changes in the Organization's business relationships with other entities. After considering these factors, the Program Administrator will determine whether changes to the Program are warranted. The Program Administrator will present any recommended changes to the [Board/Managing Partner/Managing Member], which will make a determination whether to accept, modify or reject the recommended changes to the Program.

Program Administration:

A. Oversight of the Program

The Organization's [Board of Directors/Managing Partner/Managing Member] is responsible for the development, implementation and updating of this Program and will approve the initial Program, as well as any updates. The Program Administrator is responsible for taking steps to ensure appropriate training of the Organization's personnel regarding the Program, receipt and review of reports regarding the detection of Red Flags, determining (with the assistance of the Board/Partner/Member and/or legal counsel) the steps for preventing and mitigating Identity Theft when a Red Flag is detected, and recommending updates to the Program.

B. Staff Training and Reporting

The Organizations personnel whose role requires their participation in implementing the Program will be trained by or under the direction of the Program Administrator. Training shall cover the Red Flags identified in the Program, detecting Red Flags, and reporting

and responding to detected Red Flags. The Program Administrator shall report annually to the [Board/Partner/Member] on the Organization's compliance with the Rule in terms of effectiveness of addressing Identity Theft, service provider arrangements, significant incidents involving Identity Theft and the Organization's response, and recommendations for material changes to the Program.

C. Oversight of Service Provider Arrangements

The Organization will require, by written contract, that service providers that provide services or perform activities in connection with a Covered Account have policies and procedures in place designed to detect, prevent and mitigate the risk of Identity Theft in regard to the Covered Accounts. If the service provider is a HIPAA Business Associate of the Organization, the Business Associate Agreement with that service provider shall be amended to incorporate the above requirements.

Cook County Health & Hospitals System

Patient Access

Policy Title: Patient Payment Financial Clearance Policy & Procedure		**Policy Number**:RCPAS08
Date of Original Policy: 1/1/2009 **Revised:** N/A	☐ Core Policy ☑ Area Specific Policy	**Pages:** 5

Purpose:

All patients will be appropriately notified of copayments/deductibles due for services rendered and an attempt to collect or refer the patient for adequate financial arrangements will be made by the Registration Associate.

Scope:

This policy and procedure will pertain to all Cook County Health and Hospital's System Emergency Departments.

Policy:

This policy establishes requirements for resolving patient liabilities prior to elective services being rendered at all Cook County facilities. This policy also establishes guidelines for emergent/urgent services and practices that should be followed for those related services. The objective of the Financial Clearance Policy is to secure resolution to patient liabilities proactively in order to improve the patient experience and fiscal health of the organization.

Approved By:	Date:

Procedures:

- **Emergency Room Patients:**
  In order to adhere to EMTALA guidelines, patients will not be asked to make payment on ER copayments/deductibles until they have been triaged and a full registration has been completed. EMTALA guidelines require the patient be assessed/triaged and stabilized prior to any payment arrangements being discussed with the patient.

  1. As part of the discharge process, registration associates will review the patient's insurance card to determine the appropriate ER copayment/deductible owed. Most insurance cards specify an ER copayment/deductible amount. However, in the event there is no specified ER copayment listed on the insurance card, the registration associate will attempt to validate whether or not a copayment is required by making a phone call to the insurance carrier or by prompting and validating against the electronic eligibility response. If it is determined there is a copayment required but no amount is specified, the registrar will request an estimated ER copayment from the patient in the amount of $50.
  2. The registration associate will ask the patient for their preferred method of payment (credit card, check, or cash).
  3. If the patient chooses to pay by credit card, the registration associate will process the payment and issue the patient the credit card receipt produced by the credit card machine. The payment will be entered into the cash log and the merchant receipt will be stapled to a copy of the face sheet and placed in the Patient Access safe.
  4. If the patient chooses to make payment in cash or check, the registration associate will collect the payment, enter it into the cash log and write out a receipt for the patient using the appropriate receipts issued by the cashier. The registration associate must then staple a copy of the face sheet and receipt to the payment and place it in the Patient Access safe.
  5. All Credit Card, Cash, and check payments must be logged into the Cash Receipt Record before the next patient is registered. When logging payments into the Cash Receipt record, registration associates must include the date of the payment, patient name, account #, amount received, initials of the person receiving the payment, receipt number, and method of payment.
  6. All Credit Card, Cash or check payments must be placed in the safe with a copy of the receipt and face sheet.
  7. For uninsured or underinsured patients, If the patient states they cannot make full or partial payment, they will be referred to a Financial Counselor to be screened for other financial arrangements. The registration associate will follow the appropriate referral process as specified by Patient Financial Services.

- **Central Registration Area - Outpatients:**
  Copayments, deductibles, and coinsurances, will be determined during the pre-registration process for all scheduled outpatients services when benefits are confirmed with the insurance company. Patients will be advised prior to their arrival of the expected payment on the scheduled date of service. The required payment will be noted on the patient's pre-registration documentation.

  1. The registration associate will ask the patient for their preferred method of payment (credit card, check, or cash).
  2. If the patient chooses to pay by credit card, the registration associate will process the payment and issue the patient the credit card receipt produced by the credit card machine. The payment will be entered into the cash log and the merchant receipt will be stapled to a copy of the face sheet and placed in the Patient Access safe.

3. If the patient chooses to make payment in cash or check, the registration associate will collect the payment, enter it into the cash log and write out a receipt for the patient using the appropriate receipts issued by the cashier. The registration associate must then staple a copy of the face sheet and receipt to the payment and place it in the Patient Access safe.
4. All Credit Card, Cash, and check payments must be logged into the Cash Receipt Record before the next patient is registered. When logging payments into the Cash Receipt record, registration associates must include the date of the payment, patient name, account #, amount received, initials of the person receiving the payment, receipt number, and method of payment.
5. All Credit Card, Cash or Check payments must be placed in the safe with a copy of the receipt and face sheet.
6. Patients pre-registered for elective services will be notified of their out-of-pocket responsibility prior to their arrival date. The patient will be required to bring their payment with them when they arrive for services.
7. For uninsured or underinsured patients, if the patient states they cannot make full or partial payment, they will be referred to a Financial Counselor to be screened for other financial arrangements. The registration associate will follow the appropriate referral process as specified by Patient Financial Services.
8. Patients with no insurance coverage that have failed to make adequate payment arrangements will be screened by a Financial Counselor for eligibility of financial assistance programs or payment arrangements prior to services being authorized. Elective services may be delayed or postponed if a patient has not completed all requirements into one of the Medical Assistance programs offered by CCHHS or made acceptable payment arrangements. Urgent/Stat orders will be approved for services and monitored closely for compliance with the Financial Clearance policy.

- **Inpatients (ER Admissions & Direct Admissions):**
  The Insurance Verifier will obtain full pre-certification, benefits, and eligibility information within 24 hours of admission to determine whether a patient is responsible for a deductible or coinsurance related to the admission.

1. The Insurance Verifier will either call or visit the patient in-house and ask the patient for their preferred method of payment (credit card, check, or cash).
2. If the patient chooses to pay by credit card, the registration associate will process the payment and issue the patient a credit card receipt produced by the credit card machine. The payment will be entered into the cash log and the merchant receipt will be stapled to a copy of the face sheet and placed in the Patient Access safe.
3. If the patient chooses to make payment in cash or check, the registration associate will collect the payment, enter it into the cash log and write out a receipt for the patient using the appropriate receipts issued by the cashier. The registration associate must then staple a copy of the face sheet and receipt to the payment and place it in the Patient Access safe.
4. All Credit Card, Cash or Check payments must be placed in the safe with a copy of the receipt and face sheet.
5. For uninsured or underinsured patients, If the patient states they cannot make full or partial payment, they will be referred to a Financial Counselor to be screened for other financial arrangements. The registration associate will follow the appropriate referral process as specified by Patient Financial Services.
6. Patients with no insurance coverage that have failed to make adequate payment arrangements will be screened by a Financial Counselor for eligibility of financial assistance programs or payment arrangements.

- **Patient Cash Reconciliation:**
  The Supervisors or Manager will reconcile all cash logs to the receipts and payments placed in the safes daily. Credit card payments will be reconciled and listed separately from cash and check payments prior to submission. Any discrepancies will be noted on the cash log and signed by the Director prior to submission to the Cashier. Patient Access Management will proceed with disciplinary action for violations related to missing payments, erroneous payments, or mishandling and processing of payments. Access to open safes will be limited to the Patient Access Director, Manager, and Supervisors.

- **Patient Cash Collection and Registration Script:**
  It is important to maintain professionalism and consistency when requesting payment for services. Please use the following script as a helpful tool in approaching patients for payment:

Sample Script for Registration Associates

Patient/guarantor arrives in emergency/outpatient department area:

Registration Associate: Good morning/afternoon (applicable title and name). Thank you (name of care professional if patient was escorted). My name is _____, and I am a registration associate here at (name of hospital). I'm sorry if an emergency brought you here today, and I hope things are better now. Let me explain quickly what we will be doing. Is that OK?

If patient answers no:

Registration Associate: What may I help you with before we go on?

Based on the response, it may be necessary to reconnect with the care professional or allow the patient some time to take care of some immediate need, e.g., go to the restroom, get a beverage, hand off a child.

If patient answers yes:

Registration Associate: I just need to review some of the information you have provided. We want to be sure we have complete and accurate information to file a claim with your insurance company. Let's go over this quickly, and please feel free to interrupt me if you don't understand something or if we have recorded something incorrectly. Does all of that sound OK to you?

1. *If patient is insured, registration associate reviews guarantor information and insurance information.*

Registration Associate: Great. Then let's move on. We will file an insurance claim with your insurance plan within the next 72 hours, and they should process and pay your claim within 30 days. You will receive a statement from us if your insurance company delays payment; thus, you will be aware of our progress with your insurance company. If there is an excessive delay, you may trust that we will contact you to assist us in getting your claim resolved to your satisfaction.

Your insurance has a $____ copayment for emergency/outpatient/same day department services/diagnostic services. Will you be paying by check, cash, or credit card today? (keep in mind that some elective services should have pre-registered over the phone and patient out-of-pocket payments communicated to the patient prior to their arrival).

1a. *If patient wishes to pay at this time:*

Registration Associate: Thank you. I will prepare your receipt.

There is an exchange of the payment and the receipt. Refer to policy regarding different payment methods.

Registration Associate: Thank you again, and if you have any questions, please feel free to contact our billing department at (phone number). They will be happy to assist you.

Always close with:

Is there anything else I may help you with at this time?

1b. *If patient does not wish to pay at this time:*

Registration Associate: I understand. In that case, I will refer you to the financial counseling department/customer service department to discuss additional financial arrangements.

If the patient expresses a financial hardship, the registration associate refers the patient to the financial assistance department/customer service department. The patient will not be permitted to receive elective services (non-emergent) without making the appropriate financial arrangements prior to having services rendered..

Always close with:

Is there anything else I may help you with at this time?

Cook County Health & Hospitals System **Services**		**Patient Access**
Policy Title: Pre-Registration Policy & Procedure		**Policy Number**:RCPAS09
Date of Original Policy: 1/1/2009 **Revised:** N/A	☐ Core Policy ☑ Area Specific Policy	**Pages:** 3

Purpose:

Patient Demographic Verification is the act of validating the patient's correct personal data by interviewing the patient via phone or in person. The pre-registration process will improve the integrity of the data captured and provide a reasonable amount of time to validate all information entered in Cerner. In addition, the process will improve the patient experience by providing a quick arrival process.

The purpose of the following policy and procedure is to establish an efficient process for verifying all patient demographic/financial information and making necessary corrections in Cerner.

Scope:

This policy and procedure will pertain to all Cook County Health and Hospital system entities.

Policy:

The Verifying Patient Demographics-Pre Registration Process is defined as verifying all patient demographics to ensure accurate clinical and financial processing. Patient demographics include but are not limited to: mailing address, phone number, marital status, religious preference, next of kin, emergency contact, employer information and accident details.

Approved By:	Date:

Procedures:

A. Patient Access Specialist/Pre-Registrar locates patient's information from the scheduling system or patient management system to obtain a phone number and performs the following functions:
   a. Contacts ordering physician's office to obtain patient's phone number if number is not available on Cerner account
   b. Contacts patient at home or at work
   c. Leaves brief message (withholding care specific information) on patient's voice mail to return call for pre-registration purposes (see scripting under pre-registration training tools)

B. Patient Access Specialist/Pre-Registrar completes introduction and scripted outline of call (see scripting under pre-registration training tools)

C. Patient Access Specialist/Pre-Registrar verifies the following patient data:
   a. Full and legal patient name (including middle initial)
   b. Date of birth
   c. Social security number
   d. Address
   e. Marital status
   f. Ethnic background
   g. Religion
   h. Employer name, address, phone number, occupation and status
   i. Emergency contact name, address, phone number and relationship
   j. Insurance details
   k. Medicare Secondary Payer Questionnaire (if applicable)
   l. Accident details (if applicable)

D. Patient Access Specialist/Pre-Registrar makes all necessary corrections in the patient's Cerner account.

E. Patient Access Specialist/Pre-Registrar indicates on pre-registration checklist any missing data or indicates all information elements are complete. (see pre-registration data elements checklist form)

F. Patient Access Specialist/Pre-Registrar provides instructions to the patient utilizing standard scripting (see attached scripting)
   a. Informs patient to bring photo id and insurance card
   b. Informs patient to bring method of payment (check, cash or charge)
   c. Provides driving directions, parking directions, entry directions and registration department directions

d. Provides contact information for questions or concerns including scheduling, clinical department, Financial Counselor and pre-registration

G. Prints all documents required to complete pre-registered packet and compiles
   a. Face sheet
   b. Condition of Admission (COA)
   c. Important Message from Medicare (IM) if applicable
   d. Arm bands and stickers

H. The Patient Access Specialist/Pre-Registrar delivers completed pre-registered packet to the appropriate registration area.

Cook County Health & Hospitals System

Patient Access

Policy Title: Quality Assurance Policy & Procedure		**Policy Number**:RCPAS10
Date of Original Policy: 1/1/2009 **Revised:** N/A	☐ Core Policy ☑ Area Specific Policy	**Pages:** 3

Purpose:

The purpose of this policy is to provide guidance and instruction for the implementation of Quality Assurance (QA), standards/guidelines for patient registration accuracy. This policy is specific to collecting quality data captured by registrars at the time of pre-registration and registration. Quality Assurance must be performed to ensure the highest degree of data integrity through timely collection of patient information. Failure to obtain accurate information during the intake process puts the facility at risk for inappropriate billing. Patient registration errors can result in lost revenue; partial or full denials, significant rework, dissatisfied patients and can be an overall compliance issue. The CCHHS Patient Access and Training & Development Department is responsible for maintaining this policy and procedure to reduce the number of registration errors and improve the clean claim rate and patient billing experience.

Scope:

This policy and procedure will pertain to all Cook County Health and Hospital's Systems entities and those departments and associated staff capturing patient data for the purpose of creating a registration or pre-registration within Cerner.

Policy:

The Patient Registration Quality Assurance (QA) policy is defined as the process through which a variety of different data sets within the calendar year will be reviewed and audited by trainers, supervisors, management and/or designees. A scoring system will be used with standard parameters to identify and rate registration errors and overall registration accuracy. All CCHHS affiliates will be required to rate above a goal of 98% accuracy for scheduled visits or admissions and 96% for unscheduled visits or admissions. A baseline should be determined for the current quality rating and operational performance in order to track future performance relative to a quality initiative start date.

Patient Access is also responsible for assisting in the appeal process if a denial is related to front end registration data capture. These denials are referred to as technical or administrative denials. A strong QA program eliminates repetitive errors by continuous quality auditing, education and training of management and staff.

Approved By:	Date:

Procedures:

1. Define the data elements or data sets to be tracked (refer to QA Worksheet) and the frequency of tracking. Data sets should be tracked weekly for each registrar using a combination of results from the Registration Accuracy automated tool and manual sampling. Quality Review Forms can be completed for specific examples of errors in order to communicate and re-educate registrars committing the errors.

2. After completion of the Quality Review form, a duplicate of the detailed form will be distributed to each employee and will be initialed by the employee upon receipt and review of the error with the trainer or direct supervisor. (see Quality Review form).

3. The Registration Quality Weekly Summary is used to track employee errors only and maintain weekly quality % scores as a ratio to total registrations completed by each registrar.

4. A Quality Trending Report will score and track percentage of accuracy and compare it to the goal for each Patient Access team. An employee's QA score is totaled weekly and included in the average for the weekly calculation of the Patient Access team. Each month is tracked and compared to the yearly average which should be used for employee annual reviews and the departmental annual accuracy percentages.

5. Select accounts from the Daily Registration Error Report available on the automated Registration Accuracy Tool that identifies all accounts in the system that have been registered and identified to have an error. The accuracy percentage should be calculated for each registrar as a ratio of total registrations with errors divided by total registrations.

6. Collect all paperwork affiliated with the account selection such as physician order, faxed information from physician office, etc. These items we'll be manually reviewed for accuracy and comparison to data captured within Cerner.

7. Bring up the QA data elements to be audited in the Cerner System.

8. Review all other data elements for accuracy that may not be detected by the automated accuracy tool by reviewing the account in Cerner. All forms related to the account should also be reviewed. Consistent development of the automated registration accuracy tool may occur to capture all detectible errors where reasonable.

9. A copy of each error should be retained by the trainer/supervisor to support the QA Worksheet and/or summary of errors.

10. The number of errors should be indicated for each employee.

11. Once the selected accounts are reviewed, repeat for the next employee until the weekly process is complete for each employee within your department.

12. Errors should be totaled on the QA Worksheet and a QA percentage is applied based on results.

13. At the end of the weekly QA audit, results will be shared with staff. At the end of the month, each employee will participate in a brief meeting with management to discuss QA results and an education plan for areas where the employees has repetitive errors. One-on-one re-training with the individual employee regarding their errors should have occurred prior to the monthly meeting or shortly thereafter.

14. Repeat the process for all applicable employees performing registration functions.

REFERENCES AND RESOURCES

For additional information or related Policy and Procedures, please see the following:

1. Registration Quality Review form*
2. Registration Quality Review Weekly Summary*
3. Registration Quality Trending Report*

Cook County Health & Hospitals System

Patient Access

Policy Title: Scheduling Policy & Procedure		**Policy Number**:RCPAS11
Date of Original Policy: 1/1/2009 **Revised:** N/A	☐ Core Policy ☑ Area Specific Policy	**Pages:** 2

Purpose:

The scheduling process is the act of scheduling elective or urgent services for the patient and initiating a record containing accurate personal data by interviewing the patient via phone or in person. Some services may be scheduled through information provided by a physician's office.

The purpose of the following policy and procedure is to establish an efficient process for capturing all accurate patient demographic/financial information during the scheduling process.

Scope:

This policy and procedure will pertain to all Cook County Health and Hospital system entities that schedule elective or urgent services.

Policy:

The Scheduling Process is defined as verifying all patient demographics to ensure accurate clinical and financial processing of a pre-registration/registration. Patient demographics include but are not limited to: mailing address, phone number, marital status, religious preference, next of kin, emergency contact, employer information, insurance coverage details and accident information, if applicable.

Approved By:	Date:

Procedures:

A. All requests to schedule new services begin with a completed referral in the IRIS system. The referral will specify the ordering physician and information, diagnosis, completed pre-requisite requirements, and valid patient contact and insurance information. Specified High-Dollar referrals will be reviewed by nursing staff for appropriate use of clinical resources and services before an appointment is scheduled. All other services will be scheduled in an available appointment appropriate for the patient availability request.

B. Once the appointment is scheduled the automated appointment acknowledgement system will place a call to the patient or guarantor to confirm, decline, or re-schedule their appointment. Patients must be told at the time their referral decision is made that they must complete one of the three options or their appointment will be cancelled.

C. The IRIS referral system will detect invalid contact information and the scheduler will:
    a. Contact the ordering physician's office to obtain the accurate patient's phone number if a valid number is not already available in the Patient Management System from historical visits.
    b. A patient's appointment will not be scheduled if inaccurate contact information is obtained.

D. If the automated system detects an answering machine, a brief message will be left with a return number to call for the patient to confirm, decline, or reschedule their appointment.

E. The Pre-Registration/Scheduling Unit will answer all requests to reschedule a patients appointment and will identify a suitable appointment for the patient. A pre-registration will be performed while the patient is on the phone. (Refer to the Pre-Registration Policy for details).

F. Confirmed appointments will be directly routed to the pre-registration unit as part of the automated call process.

G. For those departments that do not process referrals for services through the IRIS system or schedule follow up visits internally within departments, appointments will be scheduled directly into Cerner with accurate patient contact information, demographic information, insurance details, ordering physician information, diagnosis, and procedure scheduled.

H. The pre-registration unit will follow up with all patients to complete an accurate pre-registration. (Refer to the Financial Clearance Policy, Insurance Verification Policy, and Pre-Registration Policy for further details).

Cook County Health & Hospitals System

Patient Access

Policy Title: Timely Insurance Information Requirements Policy & Procedure		**Policy Number**:RCPAS12
Date of Original Policy: 3/18/2009 **Revised:** N/A	☐ Core Policy ☑ Area Specific Policy	**Pages:** 2

Purpose:

The Cook County Health and Hospitals System requires complete insurance coverage information for insured patients in order to secure reimbursement for services. This information is usually required prior to or at the point services are rendered. However, there are occasions when this information is not available and the patient will be required to adhere to the following policy.

Scope:

This policy and procedure will pertain to all Cook County Health and Hospital system entities that provide treatment, diagnostic services, or preventive services to patients.

Policy:

The Timely Insurance Information Requirement policy is defined in order to provide patients with clear guidelines to follow regarding their responsibility to provide insurance coverage information for the services they receive.

Approved By:	Date:

Procedures:

A. All patients with insurance coverage are required to provide the following information pertaining to their coverage in order for Cook County Health and Hospitals System to secure reimbursement for services rendered to its patients:

   a. Insurance Subscriber Name
   b. Insurance Subscriber Date of Birth
   c. Policy Number
   d. Group Number
   e. Insurance Plan Effective Date
   f. Insurance Name and type
   g. Insurance Telephone #

B. In addition to the information listed above, patients will be required to provide prior authorization or precertification information relative to the services being rendered, if their insurance plan requires such for specific services (i.e admissions or elective services).

C. Patients that present for services without complete and appropriate insurance plan coverage information will be given 72 hours to provide the appropriate insurance information to the Patient Access Area, Customer Service department, or Pre-Visit Services department respective to the services being provided.

D. If information is not received timely, the patient will be held responsible for charges associated with services rendered.

E. The patient or guarantor will also be held responsible for the charges if prior authorization or precertification was not obtained by the patient timely. This will only apply to services that require it per the patients insurance plan coverage.

Cook County Health & Hospitals System

Patient Access

Policy Title: Consent for Treatment of Minors Policy & Procedure		**Policy Number**:RCPAS13
Date of Original Policy: 3/18/2009 **Revised:** N/A	☐ Core Policy ☑ Area Specific Policy	**Pages:** 3

Purpose:

Patients who are minors have the right to treatment under specific guidelines to obtain appropriate consent. Consent to treat a minor should usually be obtained from a parent or guardian, however, that is not necessarily the case under specific circumstances.

The purpose of the following policy is to provide all admission and outpatient treatment areas with a clear guideline of obtaining a valid consent for the treatment of minors and ensuring compliance.

Scope:

This policy and procedure will pertain to all Cook County Health and Hospital system entities that provide treatment, diagnostic services, or preventive patient services to minors. This policy is in alignment with Illinois State Family Law Chapter 750; Sections 30-1 thru 30-11 (Also referred to as the Emancipation of Minors Act).

Policy:

The “Consent for Treatment of a Minor” policy is defined to ensure that proper written or verbal consent is obtained for minor’s with legal guardians/parents, emancipated minors, or minors seeking specific types of services.

Approved By:	Date:

Procedures:

A. Cook County Health and Hospitals System requires that all minors requesting medical treatment in any of its entities have a parent or legal guardian provide written consent except in the following instances as required by law:

   a. A minor that has been deemed emancipated by a court order.
   b. A minor considered emancipated through marriage
   c. A minor seeking diagnosis, treatment, or prevention of pregnancy
   d. A minor seeking diagnosis, treatment, or prevention of a sexually transmitted condition
   e. A minor seeking treatment for a sexual assault
   f. A minor seeking treatment for alcohol or drug abuse
   g. A minor that is requiring or seeking treatment related to his/her mental health

   It is important to remember that a minor can only be deemed emancipated in the State of Illinois from the age of 16 until the time they turn 18 years old. Minors younger than 16 years of age cannot be considered emancipated and are always considered to be under the custody of an authorized parent/guardian that can provide consent to treat the minor. It is also important to remember that children in the custody of DYFS (Division of Family and Youth Services) are never considered emancipated.

   Please adhere to the following policy for minors that require a parent or legal guardian provide consent for treatment:

B. As a general rule, an unemancipated minor's consent to treatment is not valid, and the consent of a parent or legal guardian must be obtained before treatment is rendered unless specified in section A. The informed consent process, which includes a thorough discussion between the care provider and the patient, together with written documentation of that discussion, should be undertaken prior to procedures. In the case of a minor, the informed consent process must also involve the parent or legal guardian. The informed consent process need not be as detailed for routine diagnostic and treatment measures, compared with the technical specificity that more complex procedures demand. However, the patient must be advised about all treatment and diagnostic procedures with respect to the proposed treatment plan, including what is to be done and why. The patient does have a right to refuse even the most routine treatment.

C. In the case of an unemancipated minor, unaccompanied by a parent or legal guardian, the physician should use his/her professional judgment as to whether any delay in treatment will likely be detrimental to the minor patient's systemic health. The physician will decide whether it is in the patient's best interest to proceed with the treatment immediately, or whether treatment can wait until a parent or legal guardian can be contacted.

D. Next, make a reasonable effort to contact the parent or legal guardian. To that end, patient charts/electronic records should be updated with all parent/guardian contact information. The record and patient management system should contain documentation of all attempts to reach a parent or guardian.

E. If you cannot reach a parent or guardian, the physician will decide to defer routine treatment or, if necessary, to palliate the patient's condition until a parent or guardian's informed consent can be obtained. Generally, it is acceptable to intervene without parental consent when immediate intervention is warranted due to traumatic injury or other truly emergent conditions but it is critical that the physician make that decision, NOT a Patient Access staff member.

F. The verbal consent or signature on a consent form of one parent is adequate. However, it is essential that the parent/guardian granting consent is legally authorized to do so. Divorces can often be highly contentious, to the point where some divorce decrees have stipulated that a non-custodial parent be stripped of parental rights. If a natural parent has no parental rights, that individual is precluded from granting consent on behalf of his or her child. Ensure that you have obtained the consent signature from the parent that can legally authorize the treatment for the minor. The right to legally grant consent for a minor child is independent of any financial obligations or arrangements that may have been made during divorce proceedings. Consequently, the parent paying the medical fees may or may not be legally authorized to grant consent. A copy of a divorce decree is required in the event it is unclear who is legally authorized to provide consent for a child of divorced parents. A copy of the court order is also required for guardians other than the patients parents that are authorized to provide consent for the minor patient.

G. Occasionally, a minor patient will be accompanied by a relative other than the parent or guardian authorized to provide consent for treatment. It is important that written consent be obtained by the authorized parent/guardian before the patient receives treatment unless the services are of such an emergent nature that only the physician decides to treat the patient. Refer to section E regarding a physician's judgment to treat a minor patient.

H. If an unaccompanied minor child presents for treatment it is NOT permissible to proceed with treatment unless the physician has determined it is of such emergent nature that not providing treatment would be detrimental to the patient's health. It is only permissible to proceed with treatment for this reason or the reasons stated in section A.

Cook County Health & Hospitals System

Patient Financial Services

Policy Title:	Patient Accounts Contractual Allowances Policy & Procedure	Policy Number:RCPFS01
Date of Original Policy: April 2009 Revised	☑ Core Policy ☑ Area Specific Policy	Pages: 1

Purpose:

It is the Intent of the Cook County Health and Hospitals System Patient Financial Services Department/Accounts Receivable Systems Management to properly and accurately state the Systems Accounts Receivable to actual expected Reimbursement at the time of Patient Account Billing.

Policy:

Cook County Health and Hospitals System's Patient Financial Services will adjust all Patient Account Claims to the expected amount of reimbursement, **at the time of billing**, in accordance with contractual agreements on all accounts for Government and Non Government Claims. Accounts for which there is no contractual agreement will be valued at the amount of total charges.

Procedures:

1. Annually, or as reimbursement changes occur, the Hospital's contract management system is loaded, by finance personnel, with the current rates of reimbursement for governmental and non-governmental payers for which privately negotiated contracts for rates of reimbursement have been negotiated.
2. Contractual allowances are automatically posted at the time of claim submission for all payers.
3. Paper Claims and claims for which a contractual was not calculated correctly and/or not posted, a manual adjustment is posted at the time of payment remit posting.

Core Procedure Operational Manual Components:

Contractual Allowance Posting Overview
Authority Levels by personnel position for posting manual contractual adjustments
Daily review procedures of contractual allowance transactions
Schedule of Payers, Contracts and rates of reimbursement - Government and Non Government for

posting automated contractual allowances Exhibit – Contractual adjustment transaction codes Exhibit – Daily Transaction Report Exhibit – Request for contractual allowance

Approved By:	Date:

Cook County Health & Hospitals System

Patient Financial Services

Policy Title: Processing Credit Balances Policy & Procedure		Policy Number:RCPFS02
Date of Original Policy: April 2009 Revised:	☑ Core Policy ☑ Area Specific Policy	Pages: 2

Purpose:

It is the intent of Cook County Health and Hospitals System Patient Financial Services Department to manage and resolve credit balance accounts and bring to closure and achieve credit balance to total Accounts Receivable at less than 3%.

Policy:

It is the Policy of Cook County Health and Hospitals System, Patient Financial Services Division, that processes be established in the account collection rules that will establish time frames and efforts that will take place to effectively investigate, manage, and resolve all credit balance accounts within **30 days** of discovery for all payers. Unresolved Medicare Credit Balances at the end of each calendar quarter require completion of the Medicare Credit Balance Report and filed with Medicare in accordance with instructions located in the Medicare Financial Management Manual, Chapter 12 – "Instructions For Medicare Credit Balance Report Activities" utilizing CMS form 838 within 30 days of the close of the quarter for which the credit balance report period applies to. Any and all other paper reporting to payers of credit balances being submitted via US Postal Service Mail are to be mailed such that tracking and proof of delivery is to be verified within 7 days of mailing/submission.

Procedures:

1. Daily, review credit balance report for new credit balances
2. Determine from account documentation source of credit balance
   a) Overpayment - Prepare refund requisition and acquire appropriate approvals. Forward to finance for payment. Document actions taken on account notes.
   b) Incorrect contractual adjustment. Correct contractual adjustment on account if within approved posting authority limits. If not within approved posting authority limits, prepare a request for contractual allowance adjustment and route for approval. Document actions taken, clearly and concisely in account notes.
   c) Adjust accounts as approvals received.

Core Procedure Operational Manual Components:

Processing Credit Balances/refunds Overview
Exhibit – Patient Accounts Daily Credit Balance Report
Processing Small Credit Balances write off/reversal
Processing Insurance/Patient Credit Balances
Processing and reporting Medicare Credit Balances
Exhibit – Medicare Quarterly Credit Balance report and guidelines
Processing late charge credits
Processing returned refunds/credit balances
Reporting to Finance returned refunds/credit balances

Approved By:	Date:

Cook County Health & Hospitals System
Patient Financial Services

Policy Title: Patient Accounts Follow Up and Collections, **Third Party Payers** Policy & Procedure		**Policy Number**:RCPFS03
Date of Original Policy: April 2009 **Revised:**	☑ Core Policy ☑ Area Specific Policy	**Pages:** 2

Purpose:

It is the intent and purpose of the Cook County Health and Hospitals System Patient Financial Services Department to insure maximum cash flow from patient account collection activities and achieve cash collections goals resultant in Accounts Aging greater than 90 days is maintained at less than 20% from third party payer sources.

Policy:

Cook County Health and Hospital System Patient Financial Services Department requires all open Patient Accounts from third party payers be managed and followed up on in an effective, timely and efficient manner based on pre-determined intervals to achieve account payment and account closure.

Follow up Procedures:

Follow up on payment of Patient Account Balances with third party payers is accomplished either by phone contact or electronic inquiry, whichever the payer has available to the provider. Patient account follow up and collection activities are to take place based on the following schedule. The volumes of account assignments, by collector, are assigned based on the payer and follow up methodology – electronic or phone inquiry. An average number of monthly account assignments by collector is approximately 2000 open Inpatient and Outpatient Accounts.

Account Follow up and Collection Activity timelines -

1. **Inpatient Claims – All Payers** - Account Values $25,000 and greater – Follow up occurs every 14 days, Accounts Values $10,000-$25,000 – Follow up occurs every 21 days, All other accounts – Follow up occurs every 30 days until account Closure

2. **Outpatient Claims** – **All Payers** – Account Values $10,000 and greater – Follow up occurs every 21 days, All other Account Balances – Follow up occurs every 30 days until account closure.

3. **In House High Balance Accounts** – **All Payers** – In house Accounts greater than $50,000 in value are to be monitored to insure continued insurance coverage and/or any other activity that may be taking place to assure payment for services rendered is protected. These in house accounts will be monitored and reviewed every 30 days to discharge.

Core Procedure Operational Manual Components:

Third Party Follow Up Overview
Exhibit – Work lists/collector workstation management
Processing Insurance Denials and Termination of Benefits
Exhibit – Insurance Denial Form
Exhibit – Claims Appeal Form
*Exhibi*t – Medical Requests Form
*Exhibi*t – Medical Requests Request Control Log
Performing Insurance Follow UP
Handling Insurance Audit Requests
Establishing Insurance for Self Pay Patients
Processing Correspondence
Insurance Denial Appeal Process
Exhibit – Request for External Appeal
Medicaid Pending
Processing DRG Changes and Discrepancies

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Approved By:	Date:

Cook County Health & Hospitals System
Patient Financial Services

Policy Title: Administrative and General Policy & Procedure		Policy Number:RCPFS04
Date of Original Policy: April 2009 Revised:	☑ Core Policy ☑ Area Specific Policy	Pages: 2

Purpose:

It is the intent of the Cook County Health and Hospitals System Patient Financial Services Department, maintains a General Department Administrative Manual to house General Departmental Administrative Policies that may also cover System wide applications.

Policy:

It is the Policy of Cook County Health and Hospitals System's Patient Financial Services Department to insure the departmental personnel are apprised of general operating policies, statements, organizational structure and/or any other exhibit that may be cross departmental and may have an impact on or provide useful information to the day to day operations of the department.

Core Procedure Operational Manual Components:

Departmental Mission, Vision and Values
Exhibit – Departmental Mission and Vision Statement
Exhibit – System Mission and Vision Statement
Departmental Organizational Chart
Exhibit – Organizational Chart
Exhibit - Charge Control and Audit Policy – Finance/CDM
Exhibit - Financial Policies – Finance
*Exhibi*t - Medical Terminology Policy – HIM
Exhibit – Terminology
Medicare 72 Hour rule policy
Letters on non-covered/advance beneficiary notices
Exhibit – ABN Notice
System Competency
Complying with JCAHO Policy
Glossary
Compliance Overview

Compliance Concepts
Employee Compliance Training and Monitoring
Guest Relations
Customer Service
Handling and Documenting Complaints
Emergency Conditions and Basic Staff Response
Exhibit – Emergency Conditions and Basic Staff Response
Confidentiality
HIPPA
Exhibit – HIPPA Policy

Approved By:	Date:

Cook County Health & Hospitals System
Patient Financial Services

Policy Title: Third Party Billing Policy & Procedure		Policy Number:RCPFS05
Date of Original Policy: April 2009 Revised:	☑ Core Policy ☑ Area Specific Policy	Pages: 2

Purpose:

It is the intent of the Cook County Health and Hospitals System Patient Financial Services Department, maintain and enforce Third Party Billing policies, practices and clean claims rate consistent with industry standards, in order that maximum available cash flow and cash acceleration from third party payers be achieved

Policy:

It is the Policy of Cook County Health and Hospitals System to accept third party payer assignment of benefits and bill electronically and by paper submission, all claims for services rendered to third party payers. Claims will be submitted in accordance and in compliance with all billing guidelines as set forth by both governmental and non-governmental reimbursement sources/payers. Claims will be submitted within four days of discharge or date of service for both inpatient and outpatient accounts.

Procedures:

1. Claims for Healthcare Services provided by Cook County will be billed on a daily basis for all payers in electronic and paper format for those payers unable to accept electronic claims submission.
2. Daily, claims submissions will be reconciled with the payer acceptance summaries and any discrepancies resolved and claims resubmitted as necessary and timely.
3. Claims are reviewed for compliance with all governmental and non- governmental payer billing edits to ensure compliance and timely and accurate payment.
4. Claims rejections bill edit compliance is to be achieved and maintained at a rate of an average 95% “clean claims” (free of errors), requiring no manual intervention for submission.

Core Procedure Operational Manual Components:

Third Party Billing Overview
Review of the UB04 for Completeness
Exhibit – UB04 Training Manual
Process for determining Inpatient and Outpatient accounts falling under the Medicare 72 hour rule
Process for moving charges from Outpatient Accounts to Inpatient Accounts
Exhibit – Medicare 72 Hour Rule
Processing Interim Inpatient Bills
Billing Outpatient Recurring Accounts
Billing for Specialty Units/clinics
Billing Third Party Payers Electronically
Exhibit – System Bill Edits
Billing Third Party Payers Manually
Billing Medicare as Secondary Payer

Billing Inpatient Medicare Accounts
Billing Outpatient Medicare Accounts
Billing for Observation Services
Billing Workmens Compensation Claims
Billing No Fault Claims
Billing Illinois Medicaid Claims
Billing Out of State Medicaid Claims
Completing the Billing Productivity Log
Exhibit – Weekly Billing productivity Log
Exhibit – Monthly Billing Productivity Log
Completing the Billing Control Log
Completing the Billing Quality Control Log
Exhibit – Weekly Billing Quality Control Log
Review and Management of the Discharged Not Final Billed Report
Review and Management of the Bill Hold Reports
Daily Claims Submission Reconciliation Procedures
Processing Late Charges/Credits
Form Locators
Condition, Occurrence and Value Codes

Approved By:	Date:

Cook County Health & Hospitals System

Patient Financial Services

Policy Title: Self Pay Time Payments (Payment Plans) Policy & Procedure		Policy Number:RCPFS06
Date of Original Policy: April 2009 Revised:	☑ Core Policy ☑ Area Specific Policy	Pages: 1 of 2

Purpose:

It is the intent of the Cook County Health and Hospitals System Patient Financial Services Department or its designee/agents to actively manage and collect Self Pay (Patient) account balances.

Policy:

Cook County Health and Hospitals System will actively pursue collection of self pay patient account balances on a payment in full basis within 30 days of receipt of patient statement. In the course of the collection process, should it be determined to be a financial burden of the patient to remit payment in full, time payment terms may be extended to the guarantor on a case by case basis for not less than $25 per month and not greater than 36 months in repayment period. A longer period of time for account balance repayment may be extended on a case by case basis requiring specific approvals by the System Director of patient Financial Services and /or the System Director Of Revenue Cycle.

Procedures:

1. All self pay accounts for which time payments have been requested will be reviewed by the Self Pay Follow up and Collections staff member assigned to the Self Pay Accounts and/or the System Self Pay Collections Designee/Agent.

2. If the requested monthly payment schedule satisfies policy guidelines, the account financial class will be changed to reflect a “time payment” account status

3. If the requested monthly payment is not within established policy guidelines, the collection representative will seek and receive a case by case approval from the System Director of Patient Financial Services for account balances greater than $10000 to $25000/ & greater than 3 years satisfaction period and from the System Director of Revenue Cycle Services for account balances greater than $25,000/ & greater than 3 years satisfaction period.

4. The assigned account representative will review, weekly, time payment delinquency reports and insure that statement data mailers are processing to the guarantor in order that arrangements be made to satisfy any delinquent open payments due.

5. Following 90 days and 3 statement data mailers, a statement will be provided to the guarantor requesting payment in full of the remaining account balance.

6. Following 120 days and 4 statement data mailers, the account will be referred to bad debt for further collection efforts.

Core Procedure Operational Manual Components:

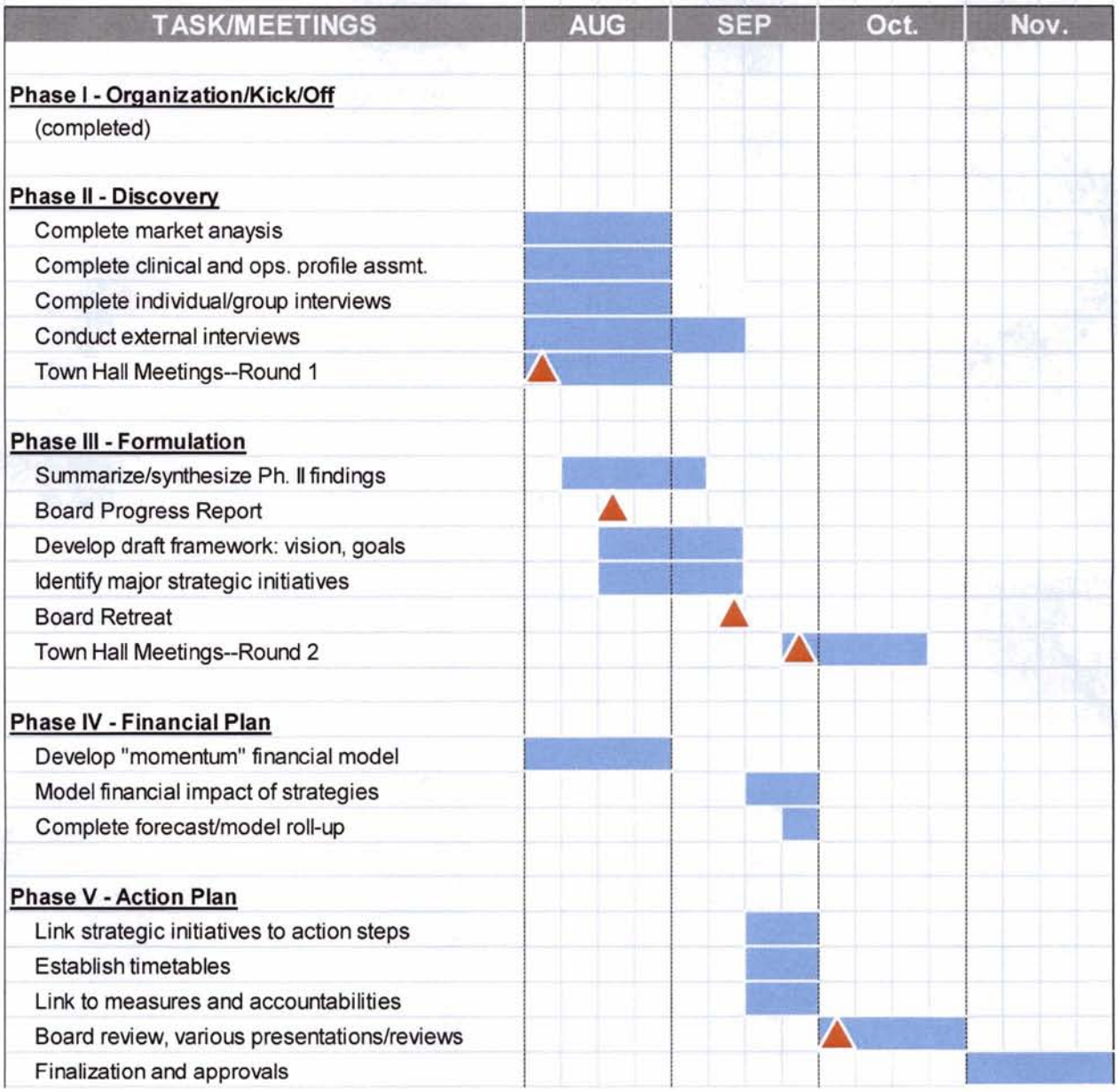
Handling Time Payments Overview
Exhibit – Time Payments “agreement to terms and conditions”
Managing delinquent time payment accounts
Transferring time payment accounts to bad debt
Exhibit – Time Payments Delinquency Report

Approved By:	Date:

Cook County Health and Hospitals System
Report of the Meeting of the Board of Directors
August 12, 2009

ATTACHMENT #4

CCHHS Strategic Planning Tasks/Timelines



Cook County Health & Hospitals System

Meeting Announcements

Cook County Health & Hospitals System
Strategic Planning Meetings for Stakeholders

The Cook County Health and Hospitals System will hold a series of town hall meetings with community stakeholders as part of its strategic planning process. The key to bringing long-term improvements to the County health system is the strategic planning process. During the coming weeks, the meetings will be held in various locations throughout the county in an attempt to gain input from all the system's stakeholders. The meetings will be held at the sites listed below.

All meetings begin at 6:00 p.m.
Please attend the meeting in your area.

South Suburban College **15800 South State Street** **South Holland**	**July 27, 2009**
Chicago Urban League **4510 South Michigan Avenue** **Chicago**	**August 3, 2009**
Malcolm X College **1900 West Van Buren Avenue** **Chicago**	**August 6, 2009**
Oakton Community College **1600 East Golf Road** **Des Plaines**	**August 13, 2009**
Truman College **1145 West Wilson Avenue** **Chicago**	**August 21, 2009**
Math and Science Academy **8601 West Roosevelt Road** **Forest Park**	**August 24, 2009**